_	1	עום	ISION OF STA	MA ATISTICAL RES	RYLAND STATE EARCH AND RE		ARTMENT O 301 W. PRESTO	F HEALTH ON STREET.	BALTIMORE	1. MARYLANI	D
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	24 hours a filled in by tapers. Page n 72 hours a	M	todovo	corporate limits, arest town)	c. LENCTH OF STA		c. CITY OR TOWN (I	Balt	ite ilmits, write Ri Limore	JRAL and give nea	rest town)
0	n 24 h filled papers hin 72	Dolde	of Hospital or in	Suest S	hospital, give street	address)	d. STREET ADDRESS		dale Rd.	e. IS I	RESIDENCE A FARM?
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	be executed within 24 hours is sician and completely filled in by ease remove carbon papers. Pag and in any event, within 72 hours	Julya Julya	le 6. COLORIO	ALLE WIDOWE			Date of Birth arch 26.1	880 9. AC	the first of the second	DER 1 FEAR IF UN hs Oays Hou	DER 24 HRS
	physician please ral, and in	10a, USUAL OC during most of	CUPATION (Cive kin f working life, ever None	d of work done 10b.	KIND OF BUSINESS O INDUSTRY	R	11. BIRTHPLACE (County & State, of the Vew York	oreign country) 1	2. CITIZEN OF WE COUNTRY?	IAT ISA
	h certificate tending phy lit. Then pl or removal,	13. FATHER'S	?	Devi	ne		14. MOTHER'S MAI	DEN NAME	Unknown		
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		18. CAUS	I. DEATH ENTE IMMEDIAT	r only one cause per USEO BY: E CAUSE (a)	line for (a), (b), and ((c).]	rehal	Meyers	where	INTERVAL ONSET AN	BETWEEN DEATH
	ohysi sign urial urial		s, If any, which a to immediate	DUE TO (b)		Cfor	Carde	- Va	recelar	- 3	> 0
	law requirentending phas been as the ben prior to b	underlyin), stating the g cause last.	CONDITIONS CONTRI	BUTING TO OFATH BUT	NOT DELAT	EO TO THE TEDMINAL	DISCASE CONDITI	ON CIVEN IN DADT	1(a) 19. WAS	AUTOPSY
	SICIAN: The land hospital or at s certificate backed for use ppt. of Health	FICAT	DENT WAS UNDER		DESCRIBE HOW INJU					YES T	NO _
	HYSICIAN he hospiti this certi etached f Dept. of		IBUTING CAUSE R, NOTIFY MEDICA E OF INJURY Mon	L EXAMINER)							(Ohoho)
	NG by be stated	MEDIC	r a.m. p.m.	19 While	e Not While at work	factory	F OF INJURY (Home, f	etc.) 20f. (City	or town)	(County)	(State)
	OR ATTENDING be retained by INECTOR: After to 3 should be ed with the Stafe		e deceased alive	17 11 1	ded the deceased t		death occurred as	19 66, to 16	the causes and o		
•	de Red		11 11-	Masi	in.	M.D.	ATTENOINC PHYS.	MED. DIRECTOR	STAFF PHYS. 22b	oate signed	-66
	Page 4 may to FUNERAL Didicator, page should be file		SICIAN'S ME (Type) CREMATION, 23b	V MA. OATE THEREOF	57 / N 1 23c. NAME OF C	- FMETERY	He	day	uster	Mud	(Ctoto)
	5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5	remotal, 24. FUNERAL	L (Specify)	11/66.	Greenmou AOORESS		rematory	Bas	ION (City, town or Limone, IR) 25b. REGISTI	Md.	(State)
	VR A15 (4) 20M 1/65	Leonar		ek Inc. B	alto. Md.	212		UL 11 18			ge.

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. COUNTY o. STATE b. COUNTY Carroll Maryland Montgomery physician ond completely filled in by the fur en please remove corbon papers. Poges 1 ovol, and in any event, within 72 haurs after MARYLAND c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) b. CITY OR TOWN (If outside corporate limits. c. LENGTH OF STAY IN 16 write RURAL and give nearest town) Rural--Sykesville 3v. lm. 17d. Chevy Chase d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street oddress) d. STREET ADORESS e. IS RESIDENCE ON A FARM? YES NO THE Springfield State Hospital 4200 Stanford Street Middle 3. NAME OF Lost DATE Doy Year DECEASED (NMN) Amanda Anderson (Type or print) DEATH IF LINDER 1 YEAR IF UNDER 24 HRS. S SEX B. DATE OF BIRTH 9. AGE (In years 6. COLOR OR RACE 7. MARRIED NEVER MARRIED Manths 9 birthday) Haurs 8 Bet white 10/13/77 female WIDOWED DIVORCED 11. BIRTHPLACE (County & Stote, or foreign country) 12. CITIZEN OF WHAT 10o. USUAL OCCUPATION (Give kind of work done 10b. KING OF BUSINESS OR COUNTRY? during most of working life, even if retired) INDUSTRY Missouri USA 14. MOTHER'S MAIDEN NAME 13. FATHER'S NAME Rudolph Studhalter Anna Hoehn 1S. WAS DECEASED EVER IN U.S. ARMED FORCES? 17 INFORMANT 16. SOCIAL SECURITY NO. (Yes, na. ar unknawn) (If yes give wor ar dates of service) permit Springfield Hospital records, Sykesville unknown no INTERVAL BETWEEN 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), ond (c).)
PART I. DEATH WAS CAUSED BY: signed by the buriol-transit p ONSET AND DEATH IMMEDIATE CAUSE (a) by **GUF TO** Canditions, if any, which gave rise to immediate couse (a). DUF TO stating the underlying couse TO HOSPITAL OR ATTENDING PHYSICIAN: The low re Poge 4 moy be retained by the hospital or ottending TO FUNERAL DIRECTOR: After this certificate has been os the lost. PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(b).

Chronic brain syndrome with cerebral arteriosclerosis with psychotic reaction. WAS AUTOPSY PERFORMED? NO YES | for 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port I or Port II of item 18.) 20o. ACCIDENT WAS UNDERLYING [OR CONTRIBUTING CAUSE OF DEATH detached (IF EITHER, NOTIFY MEDICAL EXAMINER 20e. PLACE OF INJURY (Home, form, (City or town) (County) (State) 20c. TIME OF INJURY Month, Dov. Year 20d. INJURY OCCURRED factory, street, affice bldg., etc.) Nat While ot wark ot wark 21. I certify that (this haspital) attended the deceased from saw the deceased glive an 7/15/1966, and the the deceased fram 5/28/, 1963, ta 2/15/, 1966 that (#) (we) last 1966, and that death accurred at 11:00%, fram causes and on the date stated above. saw the deceased alive an_ 22b. DATE SIGNED 22a, SIGNATURE ATTENDING MED. DIRECTOR STAFF PHYS. 7/15/66 M.D. PHYS 22d. ADDRESS Springfield State Hospital 22c. PHYSICIAN'S NAME (Type) Sykesville, Maryland Edmee J. Reeves, M. D. director, should b 23d. LOCATION (City or Town) 23c NAME OF CEMETERY OR CREMATORY (Caunty) (Stote) 23b. DATE THEREOF 23o. BURIAL, CREMATION Burial-transit 7-16-66 Sunset Burial Park St. Louis, Missouri 25b. REGISTRAR'S SIGNATURE 2So. REC'D BY REGISTRAR 24. FUNERAL DIRECTOR leavely PUMPHREY. Bethesda, Maryland

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1	MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1,	MADVIAND
# E24	09702 CERTIFICATE OF DEATH	09701
er de	1. PLACE OF DEATH a. COUNTY 2. USUAL RESIDENCE (Where deceased lived, If institution: a. STATE b. COUNTY ARRYLAND MARYLAND	Residence before admission
nours and in by the s. Pages hours aff	b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 1. C. LENGTH OF STAY IN 1b 2. LENGTH OF STAY IN 1b 2. LENGTH OF STAY IN 1b 4. Length OF STAY IN 1b 5. Length OF STAY IN 1b 6. Length OF STAY IN 1b 6. Length OF STAY IN 1b 6. Length OF STAY IN 1b 7. Length OF STAY IN 1b 7. Length OF STAY IN 1b 8. Length OF STAY IN 1b 9. Length O	L and give nearest town
filled in papers.	d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) d. STREET ADDRESS	e. IS RESIDENCE ON A FARM?
> 5	3. NAME OF DECEASED 1 First Middle Last 4. DATE Month	Oay Year
event	6. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 8. OATE OF BIRTH 9. AGE (4) years FUNDE	19 (6 R 1 YEAR IF UNDER 24 HR
п апу	OS. USUAL OCCUPATION (Give kind of work done) 1Db. KIND OF BUSINESS OR 11-BIRT HPLACE, (County & State, or foreign country) 12,	TITIZEN OF WHAT
	13. FATHER'S NAME INDUSTRY INDUSTRY INDUSTRY 14. MOTHER'S MAIDEN NAME	COUNTRY? U.SA
	John Bijler Laura Clas.	
	15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT (duy hlu) Address (Yes, no, or unknown) (If yes give war or dates of service) 2/0-32.5697 ms. Vontamalonus Han	myster, md
prior to burial, cramation,	18. CAUSE OF OEATH [Enter only one cause per line for (a), (b), and (c)-1 PART I. DEATH WAS CAUSED BY:	INTERVAL BETWEEN ONSET AND OEATH
	Conditions, If any, which \ (a)	?
	gave rise to immediate cause (a), stating the OUE TO	
		PERFORMED?
Ò	20a. ACCIDENT WAS UNDERLYING (1) OR CONTRIBUTING (1) OR CONTRIBUTI	YES NO
- 1	20c. TIME OF INJURY Month, Day, Year 2Dd. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, 20f. (City or town)	ounty) (State)
		that (I) (we) las
	saw the deceased alive on 1967, and that death occurred at 12 pm, from the causes and on	
,	Acetyl Collector M.O. ATTENOING MEO. STAFF PHYS. WEO. OIRECTOR PHYS.	ely1,1966
should be filled	NAME (Type) US got CB USh MD Hampslind, Myla	nd
	32. BURIAL EXEMATION, 236. OATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or c Burial 7/14/66 Manchester Cemetery Manchester	ounty) (State)
K	24. FUNERAL DIRECTOR AGORESS AGORESS Tipton-Eline Hampstead, Md. DATE 111 6 1966 College	R'S SIGNATURE
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MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 09707 CERTIFICATE OF DEATH requires that the death certificate be executed within 24 haurs after death physician and campletely filled in by the funeral en please remave carban papers. Pages 1 and, aval, and in any event, within 72 haurs after degft 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) 1. PLACE OF DEATH o. COUNTY Maryland Baltimore Carroll MARYLAND c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) b. CITY OR TOWN (If outside carparate limits, CLENGTH OF STAY IN 1b write RURAL and give nearest tawn) Rural - Boring Westminster e. IS RESIDENCE ON A FARM? d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS YES X NO Carroll County General Hospital 60 3. NAME OF Middle 4. DATE First Last Month Day Year DECEASED OSBORN BELT 1966 HATTIE (Type ar print) DEATH IF UNDER 1 YEAR IF UNDER 24 HRS. S. SEX 6 COLOR OR RACE DATE OF BIRTH 9. AGE (In years 7. MARRIED NEVER MARRIED Birthday) Months Haurs Days 2/10/82 WIDOWED X DIVORCED Female White 10a. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT during most of working life, even if retired) INDUSTRY USRA Maryland 14. MOTHER'S MAIDEN NAME 13. FATHER'S NAME Elizabeth Akehurst John D. Osborn 17. INFORMANT 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. Address (Yes, no, or unknown) (If yes give war ar dates of service) 212-38-2216 Mr. L. Russell Osborn, B oring, Md. 18. CAUSE OF DEATH (Enter anly ane cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY: INTERVAL BETWEEN signed by the burial-transit p ONSET AND DEATH OBSTRUCTION INTESTINAL IMMEDIATE CAUSE (a) DUE TO YMOS. BOWEL CARCINOMA OF Conditions, if ony, which gove rise ta immediate cause (o), DUE TO stating the underlying couse TO FUNERAL DIRECTOR: After this certificate has been the PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY PERFORMED? CERTIFICATION YES V NO far 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.) 20o. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20e. PLACE OF INJURY (Hame, farm, (City ar tawn) (Caunty) (State) 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED Haur o.m. Nat While factory, street, affice bldg., etc.) 1966_10. , 1966, that (I) (we) last 21. I certify that (1) (this haspital) attended the deceased fram. be retained 1966 and that death accurred at 1/22 M. fram causes and an the date stated above saw the deceased alive on 220. SIGNATURE 22b. DAJE SIGNED **ATTENDING** M.D. DIRECTOR TO HOSPITAL Page 4 may b 22d, ADDRESS 22c. PHYSICIAN'S NAME (Type) directar, shauld b 23d. LOCATION (City or Town) 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY (County) (State) 23o. BURIAL, CREMATION, REMOVAL (Specify)
Burial 7/11/66 Pleasant Grove Balto. Co. Md. 25b. REGISTRAR'S SIGNATURE 2Sa. REC'D BY REGISTRAR 24. FUNERAL DIRECTOR Marley VR A15 (4) Hampstead, Md. Tipton-Eline 20 M 1/66

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MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 09709 CERTIFICATE OF DEATH death. he law requires that the death certificate be executed within 24 haurs after death by the funeral Pages 1 and 2 and 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) 1. PLACE OF DEATH o. STATE Maryland o. COUNTY Carroll b. COUNTY BaltimoreCity ease remave carban papers. Pages 1 and in any event, within 72 haurs after MARYLAND c. CITY OR TOWN (If autside carparate limits, write RURAL and give neorest town c. LENGTH OF STAY IN 1b b. CITY OR TOWN (If outside corparate limits, write RURAL and give neorest town) lvr.llm0 d Baltimore Sykesville e. IS RESIDENCE ON A FARM? d. NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) d. STREET ADDRESS campletely filled in YES T Springfield State Hospital 2002 Girard Avenue NO 3. NAME OF Middle 4. DATE Manth Day Year DECEASED CHARLES HENRY BOWERSOX DEATH (Type ar print) IF UNDER TYEAR 9. AGE (In years IF UNDER 24 HRS. S. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED B. DATE OF BIRTH birthday) Months Haurs SepDIVORCED Male Whi te 12. CITIZEN OF WHAT 10o. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign cauntry) COUNTRY? during mast of working life, even if retired)
Plumber INDUSTRY by the attending physician transit permit. Then please crematian, ar remava, and i U.S.A Maryland

14. MOTHER'S MAIDEN NAME 13 FATHER'S NAME Charles Bowersox Elizabeth Shaffer 16. SOCIAL SECURITY NO. 17. INFORMANT IS. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknawn) (If yes give war or dates of service) 214-18-5841 Records, Springfield State Hospital INTERVAL BETWEEN 18. CAUSE OF DEATH (Enter only one couse per line far (a), (b), and (c).) signed by the burial-transit p ONSET AND DEATH PART I. DEATH WAS CAUSED BY: Uremia IMMEDIATE CAUSE (a) Page 4 may be retained by the haspital ar attending physician. DUF TO Nephrosclerosis Years Conditions, if any, which gave rise to immediate cause (o). DUE TO stating the underlying couse this certificate has been use as the PARI II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

Chronic brain syndrome associated with cerebral arteriosclerosis, with psychotic reaction. 19. WAS AUTOPSY PERFORMED? NO YES ar 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I or Part II of item 18.) 20g. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20e. PLACE OF INJURY (Hame, farm, (City or town) (County) (State) 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20f. factory, street, office bldg., etc.) Nat While at work O FUNERAL DIRECTOR: After pe 21. I certify that (1) (this haspital) attended the deceased from 8-17-64 9uly 10, 19 66that (1) (we) last . 19 __, ta_ saw the deceased alive an 7-10-66 , and that death accurred at 6.75AM, fram causes and an the date stated above. 22b. DATE SIGNED 22a. SIGNATURE MED. DIRECTOR STAFF PHYS. 7-1 -66 E M.D. director, page 3 22d ADDRESS Springfield State Hospital 22c. PHYSICIAN'S R. Acle M.D. Eduards NAME (Type) Sykesville, Maryland 2178h 230 NAME OF CEMETERY OR CREMATOR (Stote) 23b. DATE THEREOF 23d OCATION (City or Town) (County) 23a. BURIAL, CREMATION. REMOVAL (Specify) 2Sa. REC'D VR A15 (4) 20 M 1/66

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_ 1		MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
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death	death.	1. PLACE OF DEATH a. COUNTY b. COUNTY b. COUNTY b. COUNTY
after the	after	b. CITY OR TOWN (If outside corporate limits, c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL end give nearest to
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certificate be executed within 24 hours after death nding physician and completely filled in by the funeral	emove any ev	5. SEX 6. COLOR OR RACE 7. MARRIED NEVER MAKRIED DIVORCED PATE OF BIRTH 9. AGE (in years lif UNDER 1 YEAR IF UNDER 24) Months Days Hours M 10 J VIS.
e be e	and in	10a. USUAL OCCUPATION (Give kind of work done industry) 10b. KIND OF BUSINESS OR III. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT COUNTRY? LUMBER 12. CITIZEN OF WHAT COUNTRY?
ertificat ling phy	Then p emoval,	13. FATHER'S NAME Alice Hill Alice Hill
death ce	ermit. m, or re	15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT (Yes, no, or unknown) (If yes give war or dates of service) 219-05-0370 Mps. MARY Green - Sykesville, No.
6.13	natic natic	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] INTERVAL BETWE ONSET AND DEAT
nat the cian ed by	trans, crei	PART I. DEATH WAS CAUSED BY: Cirrhosis of liver, severe
res th physic	ourial	Conditions, if any, which (b) Malnutrition Jan. 1966
PHYSICIAN: The law requires that the hospital or attending physician this certificate has been signed t	the book to be	gave rise to immediate cause (a), stating the underlying cause last. (c) Anemia: cardiac failure with arrest through 7/23/66
e law atte	se as th pri	
E. The	for u	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOP PERFORMED YES NO 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
PHYSICIAN: the hospital this certifi	t. of	20a. ACCIDENT WAS UNDERLYING 2Db. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
NG PHYS by the I	3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pag with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours of the State Dept.	2Dc. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 2De. PLACE OF INJURY (Home, farm, 2Df. (City or town) (County) (State factory, street, office bidg., etc.) P.m. 19 at work at work 19 at work
ATTENDING retained by CTOR: Afte	the S	21. I certify that (I) (this hospital) attended the deceased from Jan. 1966, to July 23., 1966, that (I) (we)
OR ATTEN / be retained DIRECTOR:	3 sh with	saw the deceased alive on July 23, 19 66, and that death occurred at 7:30 M, from the causes and on the date stated about 22a. SIGNATURE 22b. DATE SIGNED
	director, page should be filed	ATTENDING MED. STAFF DIRECTOR DIRECTOR July 27, 1966 22c. PHYSICIAN'S [22d. ADDRESS]
Fage 4 may 0 FUNERAL I	ctor,	NAME (Type) Howard E. Hall, M.D. Sykesville, Maryland
TO HOSPITAL Page 4 may	dire	BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) (State) SUPER STATE OF THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) (State) SUPER STATE OF THE STATE OF TH
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	law requires that the death certificate be executed within 24 hours after death. ttending physician. has been signed by the attending physician and completely filled in by the funeral as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 prior to burial, cremation, became, and in any event, within 12 poins after death.		LACE OF DEATH		MAD	YLAND 1	2. USUAL RESIDENCE	E (Where deceased	lived, If institution: b. COUNTY	Residence before	ore admission)
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	ires that the dea physician. n signed by the a burial-transit per burial, cremation		PART I. DEATH WAS CAUSE IMMEDIATE CA	D BY: AUSE (a)	rult ple	Cores	eneral A	brown	etere	ONSET A	AND DEATH
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MARYLAND STATE DEPARTMENT OF HEALTH

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VR A15 (4) 20M 5-63

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 09715 CERTIFICATE OF DEATH completely filled in by the funeral pove corbon papers. Pages 1 and 2 yeartt, within 72 hours after death 24 hours after death. 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) o. COUNTY b. COUNTY Carroll MARYLAND c. CITY OR TOWN (If outside carparate limits, write RURAL and give neares flown) CITY OR TOWN (If autside carparate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 1b Silver Spring 11m 20910 /5 - > Rural) Sykesville 13d d. NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES NO x Springfield State Hospital 1229 Noyes Drive PHYSICIAN: The law requires that the death certificate be executed within DATE Manth 3. NAME OF First Middle Last Day Year DECEASED Cornell (Type or print) Ralph Guy DEATH 19 66 IF UNDER 1 YEAR IF UNDER 24 HRS. 9. AGE (In years S. SEX B. DATE OF BIRTH 6. COLOR OR RACE 7. MARRIED NEVER MARRIED birthday) Months Hours 5-20-91 WIDOWED DIVORCED male white rem puo or removal, and in on 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & Stote, or foreign country) 12. CITIZEN OF WHAT 10a. USUAL OCCUPATION (Give kind of work done COUNTRY? USA during most of warking life, even if retired) ottending physicion of INDUSTRY Gut. New York 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME Agusta Engalls Joseph Cornell unilitriown 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. Address 29 Noyes Drive Cornell (Yes, na, ar unknown) (If yes give war or dates of service) permit. 220-34-8453 Megnitadodennida cremation, INTERVAL BETWEEN 1B. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) buriol-transit ONSET AND DEATH PART I. DEATH WAS CAUSED BY: Congestive Heart Failure IMMEDIATE CAUSE (o) signed by Poge 4 may be retained by the hospitol or attending physician. Arteriosclerotic vascular disease Conditions, if any, which gove vears rise to immediate couse (o), DUE TO stating the underlying couse FUNERAL DIRECTOR: After this certificate has been irector, page 3 should be detached for use as the hand he filed with the State Dept. of Health prior to PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) Chronic brain syndrome associated with senile brain disease with 19. WAS AUTOPSY PERFORMED? CERTIFICATION YES NO Pneumonia. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20e. PLACE OF INJURY (Home, farm, 20d. INJURY OCCURRED (City or town) (County) (State) 20c. TIME OF INJURY Month, Doy, Year foctory, street_office bldg., etc.) Hour a.m. at wark 19 66 that (M (we) lost 21. I certify that (4) (this hospital) ottended the deceosed from 0-0 19 05 to 19.66, and that death accurred at 10:10, from causes and on the dote stoted obove. saw the deceased alive on 7-19 22b. DATE SIGNED 22a, SIGNATURE 7-20-66 M.D. DIRECTOR PHYS. director, page 3 should be filed a PHYS 22d. ADDRESS 22c PHYSICIAN'S Springfield State Hospital Heinz H. Klaatsch, M.D. NAME (Type) 23c. NAME OF CEMETERY OR CREMATOR CESVIL 23b. DATE THEREOF 23a. BURIAL, CREMATION (County) (State) REMOVAL (Specify) Lincoln Cemetery Prince Georges (0. 0 Surial 2So. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE FUNERAL DIRECTOR Georgia Ave VR A15 (4) DATE JU

RYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH funeral 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where decessed lived, If institution, Residence before admission) a. COUNTY MARYLAND b. CITY OR TOWN (if outside corporate limits c. LENGTH OF STAY IN 16 72 hours after d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES NO 3. NAME OF DATE Middle Lest Month Dev DECEASED EN OF DEATH (Type or print) 1906 and cor 6. COLOR OR RACE 7. MARRIED AGE (In years | IF UNDER 1 YEAR IF UNDER 24 HRS. 9. birthday) Months WIDOWED 1 DIVORCED OCCUPATION (Give kind of work 10b. KIND OF BUSINESS OR INDUSTRY 12. CITIZEN OF WHAT COUNTRY or foreign country) uring most of working life, even if retired 13. FATHER'S NAME 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. | 17. INFORMAN (Yes, no, or unkown) | (Ifyesgivewerordetesofservice) 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c),] PART I. DEATH WAS CAUSED BY: SCLEROTIC IMMEDIATE CAUSE (e)_ DUE TO DISEACE Conditions, if eny, which (b) geve rise to immediate cause DUE TO (a), stating the underlying cause lest. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY CERTIFICATION PERFORMED? 20 NO T 2De. ACCIDENT WAS UNDERLYING 2Db. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Pert II of item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Dev. Yeer 20d. INJURY OCCURRED 2De, PLACE OF INJURY (Home, farm, 20f. (City or town) (County) (State) factory, street, office bldg., etc.) While Not While Hour a.m at work at work 21. I certify that (I) (this hospital) attended the deceased from M, from the causes and on the date stated above. saw the deceased alive on 22b. DATE ATTENDING MED SIGNED PHYS. M.D. 22c. PHYSICIAN'S 22d. ADDRESS 23a. BURIAL, CREMATION, | 23b. (Stete) DATE 23c. NAME OF CEMETERY OR CREMATORY REMOVAL (Specify) 0 FUNERAL DIRECTOR'S SIGNATURE REC'D BY REGISTRAK 25b. REGISTRAR'S SIGNATURE VR A15 1966 DATE V

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MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND FOR STATE MEDICAL EXAMINER'S CERTIFICATE OF DEATH HEALTH DEPT PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. COUNTY b. COUNTY Carroll Maryland MARYLAND cessary, funeral may be CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) c. CITY DR TOWN (If outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 1b Westminster Westminster the 5 d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? ay is 3 to Page State E. Main St. E. Main St. No X YES 3. NAME OF Middle Last DATE Month Year DECEASED 15 (Type or print) DEATH 19 5. SEX 6. CDLOR DR RACE AGE (In years | IFUNDER 1 YEAR | IF UNDER 24 HRS DATE OF BIRTH 7. MARRIED NEVER MARRIED last birthday) Months I Davs Hours Male White DIVORCED X WIDDWED 10e. USUAL OCCUPATION (Give kind of work done | 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT COUNTRY? during most of working life, even if retired) Road work USA Maryland 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME Estie Wilhelm Kurtz Cullison 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 17. INFORMANT Address 16. SOCIAL SECURITY NO. (Yes. no. or unkown) (II yes give war or dates of service) permit. removal, EXAMINER: This certificate should be executed within 3Mr. Atlee Hampstead, Md. Cullison no INTERVAL BETWEEN 18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), end (c),) ONSET AND DEATH PART I. DEATH WAS CAUSED BY: 20 burial-transit IMMEDIATE CAUSE (a) cremation, DUE TO Conditions, If any, which (b) gave rise to immediate DUE TO cause (a), stating the 7 underlying cause last. used as a to burial, WAS AUTDPSY PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. CERTIFICATION PERFORMED? the certificate, writing the should be forwarded to the ND YES DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part 1 or Part 11 of Item 18.) 2Da. EXTERNAL CAUSE WAS PRIMARY | or CONTRIBUTING | Pa 3 shoul MEDICAL 20e. PLACE OF INJURY (Home, farm, 20f. (City or town) (County) (State) 20d. INJURY OCCURRED TIME OF INJURY Month, Day, Year factory, street, office bldg., etc.) Hour a.m. Not While at work et work Inspection 1 Inquiry and in my opinion 21. I certify that I took charge of the remains described above, held an Autopsy FI es. FUNERAL DIRECTOR: F Health or its design death resulted from: Natural causes Accident Suicide Homicide Undetermined manner CHIEF MEDICAL EXAMINER for your ASSISTANT MEDICAL EXAMINER SIGNATUR DEPUTY MEDICAL EXAMINER TO **EXAMINER'S** director. Address (Street, city, town, or county) NAME (Type) 23d. LOCATION (City, town or county) 23c. NAME OF CEMETERY OR CREMATORY (State) BURIAL, CREMATION, 23b. DATE THEREOF REMOVAL (Specify) Md. 0 Balto.Co. Buria] Grace Cemetery REC'D BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE 24. FUNERAL DIRECTOR 1966 Tipton-Eline Hampstead. Md. VR ALSME (5) 1/65

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in by		write RURAL and give nearest town) 1 No transaction 1 day Motormantic	06-1
Hed i pers. 72 h	F	d. NAME OF HOSPITAL OR INSTITUTION Of not in hospital, give street address) d. STREET ADDRESS	e. IS RESIDENCE DN A FARM?
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H Si H		18. CAUSE DF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY:	INTERVAL BETWEEN ONSET AND DEATH
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CIAN: The law requires that to spital or attending physician certificate has been signed bed for use as the burial-trant. of Health prior to burial, cre	CERTIFICATION	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a	PERFORMED?
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ATTENDING retained by rCTOR: After should be with the Stafe		21. I certify that (I) (this hospital) attended the deceased from 17-9, 196, to 7/30, 195 saw the deceased alive on 7/30, 196, and that death occurred at 75 M, from the causes and on	the date stated above
OR ATTENDING be retained IRECTOR: Air stould set with the		ATTENDING MED. STAFF	DATE SIGNED
AIL D		22c. PHYSICIAN'S 22d. ADDRESS 22d. ADDRESS	170/62
O HOSPITAL Page 4 may O FUNERAL I director, pag should be fill	-	NAME (Type) JOHN S. HARSHEY, M.D. Streke St. Westween	, md
Pag To F Sho	238	REMOVAL (Specify)	county) (State)
	24	FUNERAL DIRECTOR ADDRESS 25a. REC'D BY REGISTRAR 25b. REGISTRA	R'S SIGNATURE
VR A15 (4) 15M 4-64	4	2 - Myers, p., Westpuriola Mr DATE AUG 2 1956 VCIL	arley Judge
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Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH requires that the death certificate be executed within 24 haurs after death. by the funeral puo PLACE OF DEATH 2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission o COUNTY o STATE_ b COUNTY MARYLAND b. CITY OR TOWN (If autside carparate limits, c. LENGTH OF STAY IN 1b corparate limits, write RURAL and give negrest town) write RURAL and give nearest tawn) d. NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) d. STREET ADDRESS IS RESIDENCE ON A FARM? completely filled in NO Z YFS B4 3. NAME OF Lost 4. DATE Month Day Year corban DECEASED MARTHA (Type or print) DEATH IF UNDER 24 HRS. AGE (In years IF UNDER YEAR 6. COLOR OR RACE 7. MARRIED DATE OF BIRTH NEVER MARRIED last birthdoy) Months Dovs Hours DIVORCED WIDOWED 12. CITIZEN OF WHAT Mo. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR during most af warking life, even if retired) INDUSTRY COUNTRY? 13 FATHER'S NAME WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT (Yes, na, ar unknown) ((If yes give war or dates af service) 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) INTERVAL BETWEEN ONSET AND DEATH buriol-transit PART I. DEATH WAS CAUSED BY: mma IMMEDIATE CAUSE (o) ģ DUE TO signed | Conditions, if any, which gove rise to immediate cause (a), DUE TO stating the underlying cause has been the last. 19. WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) CERTIFICATION YES NO O FUNERAL DIRECTOR: After this certificate PHYSICIAN: Por 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II of item 18.) 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH detoched (IF EITHER, NOTIFY MEDICAL EXAMINER) 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Hame, farm, (City or town) (County) (State) 20c. TIME OF INJURY Month, Day, Year Haur a.m. factory, street, affice blda., etc.) 7/30 1966, that (1) (we) last 21. I certify that (I) (this haspital) attended the deceased fram_ 1966 to 19 66, and that death occurred at 7 3 M, fram causes and an the date stated above sow the deceased alive on 22b. DATE SIGNED 22a. SIGNATURE DIRECTOR M.D. PHYS. 22d. ADDRESS 22c. PHYSICIAN'S NAME (Type) director, should b 23o. BURIAL CREMATION. 23b. DATE THEREOF 23d. LOCATION (City or Town) (County) (Stote) REMOVAL (Specify) SUNERAL DIRECTOR 250. REC'D BY REGISTRAR 2Sb. REGISTRAR'S SIGNATURE VR A15 (4) DATE AUG 20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

- Mensachery Commell (Sugare MRRTHA JAME JULY 30 0 50 JULY 29 1966 finette white less trumpter Til to Sal Betty Performance Edwar & Doma Edward Bries Treatment Breeze 8/1/66 JOCE CETATION SHELDER, W. V. 25 mones & Sentimate Med Consul

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 09721 CERTIFICATE OF DEATH PHYSICIAN: The low requires that the deoth certificate be executed within 24 hours after deoth in by the funeral rs. Pages 1 and 2 haurs after death deoth 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission) o. COUNTY Carroll b. COUNTY o. STATE Maryland MARYLAND Baltimore City c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) C. LENGTH OF STAY IN 1b. b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Sykesville Byrs.lmo.7dys. Baltimore papers. e. IS RESIDENCE ON A FARM? and completely filled in d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street oddress) d. STREET ADDRESS nin 72 2628 N. Calvert St. Springfield State Hospital YES NO 4. DATE 3. NAME OF Middle Lost Doy Year Corbon N. First DECEASEO eyent, WILLIAM DILLON 18 MCCAFFREY JULY 19 66 **OEATH** (Type or print) IF UNDER 1 YEAR | IF UNDER 24 HRS. DATE OF BIRTH 9. AGE (In years S. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED please remove birthdoy) Months Doys Hours 5-23-1889 Mala White WIDOWED DIVORCED ond in any 10o. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. 8IRTHPLACE (County & Stote, or foreign country) 12. CITIZEN OF WHAT COUNTRY? during most of working life, even if retired)
Printer INDUSTRY New York U.S.A. 14 MOTHER'S MAIDEN NAME 13. FATHER'S NAME or removol, Edmund M. Dillon Virginia McCaffrey 17. INFORMANT 1S. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. (Yes, no, or unknown) (If yes give wor or dotes of service) 122-20-0341 Records, Springfield State Hospital INTERVAL BETWEEN 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).)
PART I. DEATH WAS CAUSED BY: signed by the buriol-transit p ONSET AND DEATH Arteriosclerotic cardiovascular disease IMMEDIATE CAUSE (a) Poge 4 may be retained by the hospital or attending physician. DUE TO Years Generalized arteriosclerosis Conditions, if ony, which gove rise to immediate couse (o), DUE TO stating the underlying couse as the O FUNERAL DIRECTOR: After this certificate has been lost. 19. WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) for use (Schizophrenic reaction, paranoid type NO E 20b. OESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.) 20o. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH detached (IF EITHER, NOTIFY MEDICAL EXAMINER Stote Dept. (City or town) (Stote) 20c. TIME OF INJURY Month, Ooy, Yeor 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, (County) foctory, street, office bldg., etc.) Hour o.m. Not While ot work 21. I certify that (I) (this haspital) attended the deceased fram-saw the deceased glive an 7-18-06 19 and the ___, 19____, that (I) (we) last to 7-18-06, 19, mar (1) (we) lust 6-11-58 should and that death accurred at saw the deceased alive an 22b. DATE SIGNED 22o. SIGNATURE ATTENDING 7-18-66 M.D. DIRECTOR PHYS PHYS. director, poge should be filed Springfield State Hospital 22d. ADDRESS 22c. PHYSICIAN'S R. G. Lajonchere, M. D. Sykesville, Maryland NAME (Type) 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (County) (Stote) 23b. DATE THEREOF 23o. BURIAL, CREMATION, REMOVAL (Specify)

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24. FUNERAL DIRECTOR Brookfr July Anne Arundel 2Sb. REGISTRAR'S SIGNATURE 2So. REC'D BY REGISTRAR Charles 1966 DATE JUL

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH funeral 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before edmission) a. COUNTY b. COUNTY 42年 MARYLAND b. CITY OR TOWN (if outside corporate limits. c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearast town) write RURAL end give nearest down nonchur d. NAME OF HOSPITAL OR INSTITUTION (if not In hospital, give street address) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? hours many YES NO etel NAME OF papers 72 h First Middle Last 4. DATE Month Dev Year DECEASED OF 5 (Type or print) DEATH 19 6. COLOR OR RACE 7. MARRIED NEVER MARRIED DATE OF BIRTH AGE (In years | IF UNDER 1 YEAR IF UNDER 24 HRS. last birthday) Months Days WIDOWED IL DIVORCED 1Db. KIND OF BUSINESS OR INDUSTRY 10a. USUAL OCCUPATION (Give kind of work 11. BIRTHPLACE (County & State, or lorgion country) 12. CITIZEN OF WHAT COUNTRY? done during most of working life, even if retired) JOMSE WIA 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME 15. WAS DECEASED EVER IN U.S. ARMED FORCES? I 16. SOCIAL SECURITY NO. I 17. INFORMANT (Yes, no, or unkown) | (if yes give we ror dates of service) 18. CAUSE OF DEATH [Enter only one cause per line for (e), (b), end (c).] INTERVAL BETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) DUE TO Conditions, if any, which gave rise to immediate cause DUE TO (e), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(n) | 19. WAS AUTOPSY CERTIFICATION PERFORMED? NO use 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Pert II of item 18.) 20a. ACCIDENT WAS UNDERLYING TI OR CONTRIBUTING [] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) defached After 20c. TIME OF INJURY 20d. INJURY OCCURRED I 20e. PLACE OF INJURY (Home, farm, 20f. (City or town) (County) (State) Month, Day, Yeer factory, street, office bldg., etc.) While Not While Hour a.m. et work et work y be retain RECTOR: p.m wen 30 21. I certify that (I) (this hospital) attended the deceased from. saw the deceased alive on-22b. DATE 22a. SIGNATURE ATTENDING PHYS. DIRECTOR PHYS. Jaurie M.D. page 22d. ADDRESS death. Page O FUNERA 22c. PHYSICIAN'S NAME (Type) ector, filed NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county (State) 23a, BURIAL, CREMATION, 23b DATE THEREO REMOVAL (Specify) 0 = 3 25. REC'D BY REGISTRAR REGISTRAR'S SIGNATUR 24 FUNERAL DIRECTOR'S SIGNATURE ADDRESS 25b. VR A15 (4) 1936 15M 7/61

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MARYLAND STATE DEPARTMENT OF HEALTH

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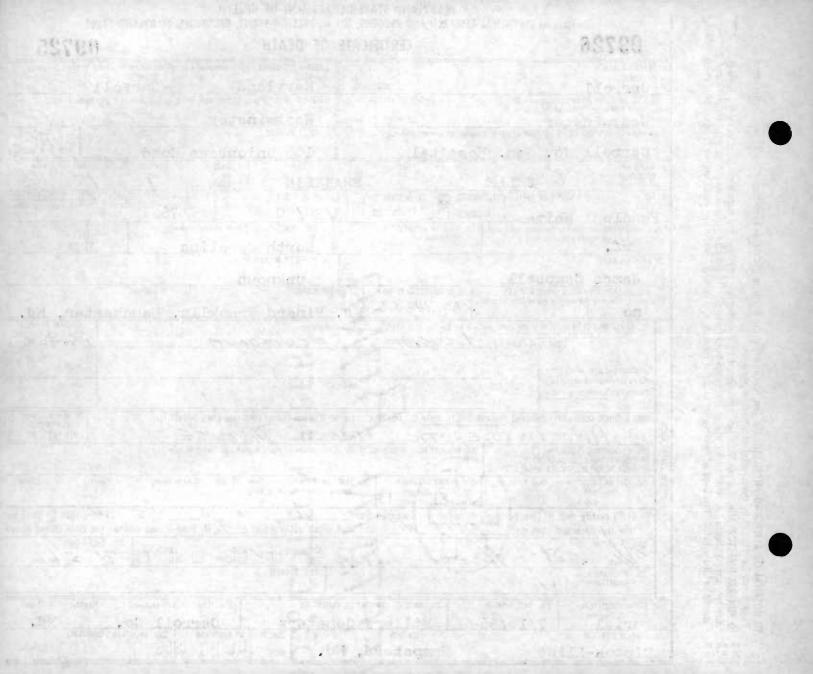
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MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND FOR STATE 09725 MEDICAL EXAMINER'S CERTIFICATE OF DEATH HEALTH DEPT. 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) e. COUNTY b. COUNTY Maryland Carroll Carroll MARYLANO Department after death. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) c. CITY OR TOWN (If outside corporete limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 1b Westminster 45 Vrs Westminster the 5 d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) d. STREET AOORESS e. IS RESIDENCE ON A FARM? 2 8 State 178 Penna. Avenue Penna. Avenue NO IK YES and and 3. NAME OF First Middle DATE Month Oay Year Last DECEASED MILDRED 19 66 NAOMI FISHPAUGH July 10 (Type or print) DEATH 2 with within 5. SEX AGE (In years | IF UNOER 1 YEAR | IF UNDER 24 HRS. 6. COLOR OR RACE OATE OF BIRTH 9. 7. MARRIEO CO NEVER MARRIEO last birthdey) | Months | Oays Pages Hours white female Nov. 3. 1913 WIOOWED : OIVORCED [and 10a. USUAL OCCUPATION (Give kind of work done | 10b. KINO OF BUSINESS OR 11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT during most of working life, even if retired) INOUSTRY COUNTRY? Eastview. Carroll Co. housewife and sewing factory U.S.A. pages in any 13. FATHER'S NAME 14. MOTHER'S MAJOEN NAME Samuel Seipp Joanna Deagen File 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address " in pencil in Examiner's Of (Yes, no, or unkown) | (If yes give war or dates of service) Bond Street permit. removal, be executed within pending" in pencil i Walter L. Seipp Westminster. 18. CAUSE OF DEATH [Enter only one cause 18] line for (a), (b), and (c).] INTERVAL BETWEEN ONSET AND/OEAT PART I. OEATH WAS CAUSED BY burial-transit cremation, or IMMEDIATE CAUSE (a **OUE TO** Conditions, if eny, which geve rise to immediate **OUE TO** EXAMINER: This certificate should cause (e), stating the 60 undarlying couse lest. ed as burial WAS AUTOPSY PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO GEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. PERFORMEO? YES [NO SE DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) g 6 20a. EXTERNAL CAUSE WAS PRIMARY OF CONTRIBUTING CAUSE OF DEATH. should ent, pri 3 shou MEDICAL 20d. INJURY OCCURRED | 20a. PLACE OF INJURY (Homa, ferm, TIME OF INJURY Month, Day, Year 20f. (City or town) (County) (State) factory, street, office bidg., etc.) Hour a.m. Whlla Not While at work _ _ et work Inquiry and in my opinion 21. I certify that I took charge of the remains described above, held an Autopsy Inspection death resulted from:_ Natural causes Suicide Homicide Undetermined manner CHIEF MEDICAL EXAMINER Page 22. DATE SIGNED ASSISTANT MEDICAL EXAMINER SIGNATUR 10 OEPUTY MEDICAL EXAMINER **EXAMINER'S** Address (Steet) cht, kollen, of bout to director. NAME (Typa) 23d. LOCATION (CULT) town of enterior BURIAL, CREMATION, REMOVAL (Specify) OATE THEREOF NAME OF CEMETERY OR CREMATORY 23b. Westminster, RD , Md. Krider's Cemetery buria 25b. REGISTRAR'S SIGNATURE **AOORESS** 25a. REC'O BY REGISTRAR! **FUNERAL DIRECTOR** VR ALSME (5)

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Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 09726 CERTIFICATE OF DEATH 09725law requires that the death certificate be executed within 24 haurs after death filled in by the funeral papers. Pages 1 and PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. COUNTY
Carroll o. STATE Maryland b. COUNTY Carroll MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) C. LENGTH OF STAY IN 1b papers. Pagi hin 72 hours o Westminster Westminster d NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street oddress) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? within 72 Carroll Co. Gen. Hospital 106 Uniontown Road NO y YES 3. NAME OF 4. DATE remave carban First Middle Last Month Doy Yeor DECEASED OF DEATH BELLE FRANKLIN 1966 (Type or print) 1 YFAR IF UNDER IF UNDER 24 HRS. S. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED DATE OF BIRTH 9. AGE (In years lost birthdoy) Months Dovs Hours 20/90 WIDOWED DIVORCED Female White 12. CITIZEN OF WHAT 10o. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11, BIRTHPLACE (County & Stote, or foreign country) physician ar her please r during most of working life, even if retired) COUNTRY? North Carolina USA f3. FATHER'S NAME 14. MOTHER'S MAIDEN NAME removal, James Campbell unknown 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address (Yes, no, or unknown) (If yes give wor or dotes of service) Vinard Franklin, Manchester, Md. no crematian, INTERVAL BETWEEN 1B. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).) ONSET AND DEATH burial-transit PART I. DEATH WAS CAUSED BY PNEUMONIA IMMEDIATE CAUSE (o) signed by DUF TO burial Canditions, if ony, which gove rise to immediate couse (o). DUE TO aftending | stoting the underlying couse has been the last. WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) W NO RTERIO SCLEROTIC this certificate by the haspital ar for 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.) 20o. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH detached (IF EITHER, NOTIFY MEDICAL EXAMINER) 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, (City or town) (County) (Stote) 20c. TIME OF INJURY Month, Day, Year foctory, street, office bldg., etc.) Hour o.m. Not While ot work O FUNERAL DIRECTOR: After 1966 1966, that (1) (we) last 21. I certify that (I) (this hospital) oftended the deceased from be retained and that death occurred at 4 3 M, from couses and on the dote stoted obove. 1966 saw the deceased alive an 22b. DATE SIGNED MED. STAFF inen M.D. DIRECTOR 22d. ADDRESS 22c. PHYSICIAN'S NAME (Type) director, 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) 23o. BURIAL, CREMATION 23b. DATE THEREOF (County) (Stote) REMOVAL (Specify) 7/18/66 Md. Millers Cemetery Carroll Co. Burial ADDRESS 2So. REC'D BY REGISTRAR 2Sb. REGISTRAR'S SIGNATURE 24. FUNERAL DIRECTOR 1966 Hampstead, Md. Tipton-Eline 20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH



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1	MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL DESEABLY AND DECORDS 301 W. PRESTON STREET, BALTIMORE 1. M.	AARYLAND
M	09723 CERTIFICATE OF DEATH	09727
	1. PLACE OF DEATH • COUNTY 2. USUAL RESIDENCE (Where deceased lived, If institution: Re • STATE MARYLAND 2. USUAL RESIDENCE (Where deceased lived, If institution: Re • STATE MARYLAND	esidence before admission) arroll
	b. CITY OR TOWN (if outside corporate limits, c. LENGTH OF STAY IN 1b c. CITY OR TOWN (if outside corporate limits, write RURAL and	give necrest town)
5	Manchester 6 whs Westminster	ola 1
2	1 - 11: 1 Alice 1/ - a Teal	IS RESIDENCE ON A FARM?
10	Long the reality from	Dey Yeer
	DECEASED (Type or print) Sarah ANN Goodwin DEATH July	4 1966
	5. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 8. DATE OF BIRTH 9. AGE (In years F UNDER 1)	YEAR IF UNDER 24 HRS.
	temale white WIDOWED DIVORCED FEB 3, 1884 82 yr.	
	done during most of working life, even if retired)	ZEN OF WHAT COUNTRY?
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i	15 WAS DECEASED EVED IN HIS ADMED CODOCES 144 COCIAI SECURITY NO. 1.37 ENTENDENTENT	
7	No No 215-20-9616 Charles Byers Carroll Street Wes	tminsk1
	18. CAUSE OF DEATH [Enter only one cause per line for (e), (b), and (c).]	INTERVAL BÉTWEEN ONSET AND DEATH
	PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) arterioscleratic Caudio	5 cares
	4221 DUE TO UNDER DARREST	1
	geve rise to immediate cause (b)	
ì	(e), staing the underlying	
	(6)	1(e) 19. WAS AUTOPSY
		YES NO
0	20a. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
	20c. TIME OF INJURY Month, Dey, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, ferm, 20t. (City or fown) (Coun factory, street, office bldg., etc.)	ity) (Stete)
		26 de 18 (10) (10) les
		(1)/(we) last above.
5	22e. SIGNATURE	22b. DATE
- /	M.D. PHYS. DIRECTOR PHYS.	SIGNED
, ,	22c. PHYSICIAN'S NAME (Type) We H FOATL M.D. 22d. ADDRESS MAKE (Type) We H FOATL M.D. MANCHESTER, N.	12 7/4/6
	230. BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county	(Stete)
0	BURIAL JULY 8, 1966 MEADON BRANCH CEM. MESIMINOVER	40-
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Division of STATISTICAL RESEARCH AND RECORDS, 301 W, PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH 09723 by the funeral Pages 1 and 2 24 haurs after death. 2. USUAL RESIDENCE (Where deceosed lived, if institution; Residence before admission) PLACE OF DEATH o. County Carroll o. STATE b. COUNTY Maryland Allegany

c. CITY OR TOWN (If autside carparote limits, write RURAL and give nearest town) Maryland MARYLAND haurs ofter c. LENGTH OF STAY IN 1b. b. CITY OR TOWN (If outside corporate limits, write RURAL and give neorest town)
Sykesville 21502 Byrs.6mos.21dv Cumberhand papers. filled in I e. IS RESIDENCE ON A FARM? d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS 725 Bedford St. transit permit. They please remave carban paper: crematian, ar removal, and in any event, within 72 Springfield State Hospital Allegany County Infirma YES 🗌 NO. DATE 3. NAME OF First Middle Day Year campletely DECEASED JULY 28 19 66 TRENE MAY (Type or print) HATNES DEATH requires that the death certificate be executed IF UNDER 1 YEAR IF UNDER 24 HRS. S SEX B. DATE OF BIRTH AGE (In yeors 6. COLOR OR RACE 7. MARRIED X NEVER MARRIED lost birthdoy) Months Doys Hours WIDOWED **X** X DIVORCED Female White -22-92 10o. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & Stote, or foreign country) 12. CITIZEN OF WHAT during most of working life, even if retired)
Housewife COUNTRY? INDUSTRY physician Maryland
14. MOTHER'S MAIDEN NAME II S Own home 13. FATHER'S NAME Asa Shanholtz Katie (Maiden name unknown) 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT (Yes, no, or unknown) (If yes give wor or dotes of service) No Records. Springfield State Hospital Unknown INTERVAL BETWEEN 1B. CAUSE OF DEATH (Enter only one cause per line for (o), (b), and (c).) signed by the burial-transit p DASET AND DEATH PART I. DEATH WAS CAUSED BY: Uremia IMMEDIATE CAUSE (o) by DUE TO burial, Weeks Conditions, if ony, which gove Renal failure rise to immediate couse (a). DUF TO stoting the underlying couse Page 4 may be retained by the haspital ar attending peen d far use as the af Health prior ta Years (d) Nephrosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0)

Chronic brain syndrome associated with cerebral arteriosclerosis, with WAS AUTOPSY PERFORMED? TO FUNERAL DIRECTOR: After this certificate has NO psychotic reaction. 200. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 1B.) OR CONTRIBUTING CAUSE OF DEATH detached (IF EITHER, NOTIFY MEDICAL EXAMINER) with the State Dept. 20c. TIME OF INJURY Month, Doy, Yeor 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, 20f. (City or town) (County) (Stote) Not While foctory, street, office bldg., etc.) ot work at work _____, and that death occurred at 8:15 Mr. from raises and as the hat (I) (we) last 21. I certify that (1) (this hospital) attended the deceased from_ 7-28-66 saw the deceased alive an 19 220. SIGNATURI 22b. DATE SIGNED **ATTENDING** 7-28-66 X DIRECTOR PHYS. director, page should be filed 22d. ADDRESS Springfield State Hospital PHYSICIAN'S Antonius Glahn. NAME (Type) Sykesville, Maryland 2178h 23d. LOCATION (City or Town) 23c. NAME OF CEMETERY OR CREMATORY (County) (Stote) 23o. BURIAL, CREMATION 23b. DATE THEREOF REMOVAL (Specify) CUMBERLAND, MD. SUNSET MEMORIAL PARK 2Sb. REGISTRAR'S SIGNATURE 2So. REC'D BY REGISTRAR 24. FUNERAL DIRECTOR CUMBERLAND, MD. VR A15 (4) 20 M 1/66 Marley Judge 1966 DATE AUG

MARYLAND STATE DEPARTMENT OF HEALTH

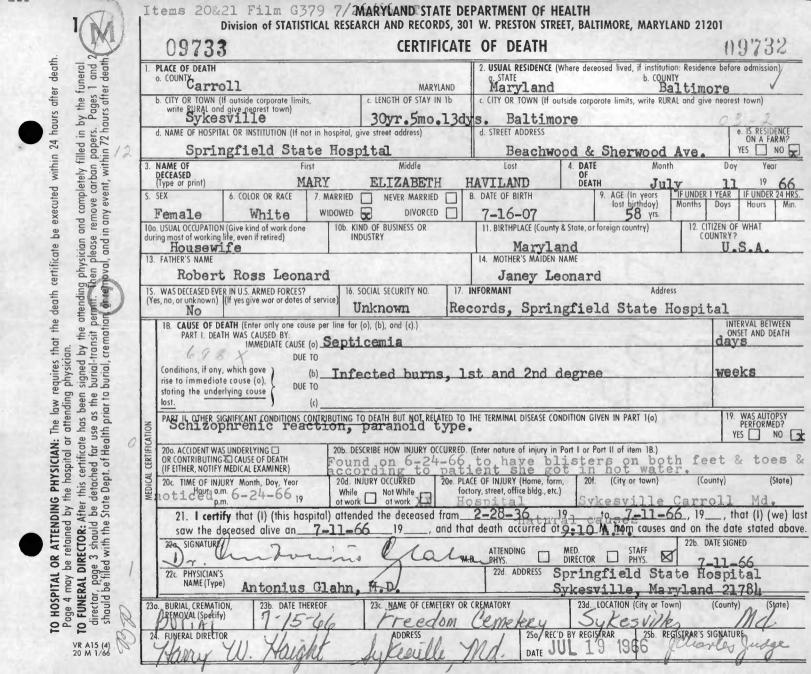
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MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH 09731 low requires that the death certificate be executed within 24 hours ofter death and completely filled in by the funeral remove corbon papers. Pages, and in in onv event, within 72 hours offer theuth 2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission) PLACE OF DEATH b. COUNTY Carroll Carroll Maryland MARYLAND b. CITY OR TOWN (If outside carparote limits, write RURAL and give nearest town) c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 16 Hampstead Hampstead e. IS RESIDENCE ON A FARM? d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS 128 N. Main St. 128 N. Main St. YES NO X 3. NAME OF Middle 4. DATE First Lost Month Doy Year DECEASED 19 66 27 Hale Jacob Howare d (Type or print) DEATH IF UNDER 1 YEAR IF UNDER 24 HRS. S. SEX 6. COLOR OR RACE B. DATE OF BIRTH 9. AGE (In years 7. MARRIED NEVER MARRIED birthdoy) Manths Hours 1/20/99 Male White DIVORCED WIDOWED 10o. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT during most of working life, even if retired)
Inspector of acc'ts. COUNTRY? Maryland 13. FATHER'S NAME 14 MOTHER'S MAIDEN NAME Laura Alban Jacob Hale 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address (Yes, na, ar unknawn) ((If yes give war ar dotes of service Hampstead. Md. Mrs. Anna Hale no 1B. CAUSE OF DEATH (Enter only one couse per line for (6), (6), PART I. DEATH WAS CAUSED BY: INTERVAL BETWEEN signed by the buriol-transit p ONSET AND DEATH IMMEDIATE CAUSE (o) DUE TO Canditians, if any, which gave rise to immediate couse (a), DUF TO stating the underlying couse as the O FUNERAL DIRECTOR: After this certificate has been lost. 19. WAS AUTOPSY PERFORMED? PART II, OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) NO PHYSICIAN: for 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I or Part II of item 1B.) 20o. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Manth, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, (City or town) (County) (State) Hour o.m. Nat While factory, street, office bldg., etc.) of work ot wark 1966, that (1) (we) last 21. I certify that (1) (this haspital) attended the deceased fram 1966 say the deceased alive an_ and that death accurred at_ 3 4 M, fram causes and an the date stated above SIGNATURE/ 22b. DATE SIGNED M.D. DIRECTOR PHYS director, poge should be filed 22d. ADD BESS PHYSICIAN'S NAME (Type) 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) 23b. DATE THEREOF 23o. BURIAL, CREMATION (County) (Stote) 7/29/66 Hampstead Hampstead
REGISTRAR | 25b. REGISTRAR'S SIGNATURE Md. 2Sa. REC'D BY REGISTRAR 24. FUNERAL DIRECTOR VR A15 (4) Hampstead, Md. Tipton-Eline 1966 Ocharles 20 M 1/66 DATE

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1		MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND	
FOR STATE		09732 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 09731	
HEALTH DEPT.	1.	PLACE DF DEATH a. COUNTY Carroll MARYLAND 2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admi b. COUNTY Maryland Carroll	ission
y delay is recessary, and 3 to the funeral M3. Page 5 may be the State Department 72 hours after death.	-	b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 1b c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)	town)
may may	L	Westminster Hampstead 06-/	
De Santha		d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) d. STREET ADDRESS e. IS RESID ON A FAF	RM?
Page Page State Hours			0 X
ny de my M3. The S hr	3.	NAME OF First Middle Last 4. DATE Month Day Year DECEASED OF TOUTS E. RSTELLA HARRIS DEATH 7 13 1964	,
	5.	SFX 6 COLOR OR RACE 7 MADDIES MULTIPLE MADDIES 18 DATE OF BIRTH 9. AGE (In years FUNDER 1 YEAR IF UNDER 2	
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along aft.	13	3. FATHER'S NAME 14. MOTHER'S MAIDEN NAME	
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250		5. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address Ves, no, or unknown) (If yes give war or dates of service)	
within pencil in miner's permit. removal,	-	no 213-30-2030 A Mr. T. E. Harris Hampstead, Md.	VEEN
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cerritin ded ld b prio	CERTIFICAT	20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
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INER: The cifficate, be forw lige 3 sh	MEDICAL	Hour a.m. 7 - 4 1966 at work at work of the street, white was at work of the street of	W
EXAMINER: certification to consider the found be found be follows. Rr. Page 3 signated ag	-	21. I certify that I took charge of the remain, described above, held an Autopsy [], Inspection [X], Inquiry [], and in my or	oinio
the certific the certific 4 should be ir files. CTOR: Page designated		death resulted from: Natural causes , Actident , Suicide , Homicide , Undetermined manner	
		ACTUAL CHIEF MEDICAL EXAMINER	GNED
- C C		SIGNATURE M.D. ASSISTANT MEDICAL EXAMINER DEPUTY DEPUTY MEDICAL EXAMINER DEPUTY DEPUT	66
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O DEPUTY M please exec director. Pr retained for O FUNERAL of Health o	23	3a. BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county)	(0)
可見事を		Burial 7/14/66 Immanuel Lutheran Baltimore Md.	•
6	2	4. FUNERAL DIRECTOR ADDRESS Tipton-Eline Fun. Home, Hampstead, Md. PATE JUL 15 1966 ADDRESS ADDRE	-
VR A15ME 3500 4-64	3	Tipton-Eline Fun. Home, Hampstead, Md. DATE JUL 15 1996	

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MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH 24 haurs after death death physician and completely filled in by the funeral en please remave carban papers. Pages 1 and over, and in any event, within 72 haurs after death 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) 1. PLACE OF DEATH o. STATE Maryland Carroll o. COUNTY b. COUNTY MARYLAND c. CITY OR TOWN (If autside carparate limits, write RURAL and give nearest tawn) b. CITY OR TOWN (If outside carparate limits. c. LENGTH OF STAY IN 1b (Rural) Sykesville 16d Ov Om Baltimore City 21217 d. NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? 626 Baker Street YES NO X Springfield State Hospital requires that the death certificate be executed within 3. NAME OF Middle Lost DATE Doy Year DECEASED Alonzo (NMN) Hill 8 66 19 DEATH (Type or print) IF UNDER 1 YEAR IF UNDER 24 HRS. S SEX 8. DATE OF BIRTH AGE (In years 6. COLOR OR RACE 7. MARRIED TX: NEVER MARRIED last birthday)
66 yrs. Manths Haurs Days male Negro 5-12-00 WIDOWED DIVORCED 10a, USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT during most of working life, even if retired) INDUSTRY COUNTRY? Maryland 14. MOTHER'S MAIDEN NAME 13. FATHER'S NAME removal William Hill Annie Estep 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, ar unknown) (If yes give war or dates af service)
unknown 16. SOCIAL SECURITY NO. INFORMANT Address unknown Hospital Records crematian, 18. CAUSE OF DEATH (Enter anly one cause per line for (o), (b), and (c).) INTERVAL BETWEEN ONSET AND DEATH burial-transit PART I. DEATH WAS CAUSED BY: Acute Congestive Heart Failure minutes IMMEDIATE CAUSE (o) þ physician. DUE TO signed ! Canditians, if any, which gove Diabetic Coma hours rise to immediate cause (a). DUE TO stating the underlying couse Page 4 may be retained by the haspital or attending as the FUNERAL DIRECTOR: After this certificate has been history Diabetes Mellitus PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) 19. WAS AUTOPSY PERFORMED? Chronic brain syndrome, cerebral arteriosclerosis with for use NO YES psychotic reaction 20g. ACCIDENT WAS UNDERLYING [205, DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II of item 18.) OR CONTRIBUTING CAUSE OF DEATH detached (IF EITHER, NOTIFY MEDICAL EXAMINER) 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Hame, farm, (City or tawn) (County) (State) 20c. TIME OF INJURY Manth, Day, Year Hour a.m. factory, street, office bldg., etc.) Not While at wark 66 to 19 66 that (F (we) last 21. I certify that (this hospital) attended the deceased from 19 1066 and that death accurred of 4 A.M., fram causes and on the dote stoted above. saw the deceased alive an 22b. DATE SIGNED 22a, SIGNATURE STAFF PHYS. ATTENDING 7-8-66 DIRECTOR M.D. PHYS directar, page shauld be filed 22d. ADDRESS 22c. PHYSICIAN'S NAME (Type) A. Arengo, M.D. Springfield State Hospital 23a. BURIAL CREMATION. 23b. DATE THEREOF 234 NAME OF CEMETERY OR CREMATOR LOCATION (City or Town) (County) (State) REMOVAL (Specify) 25b. REGISTRAR'S SIGNATURE 250. REC'D BY REGISTRAR 24.) FUNERAL DIRECTOR VR A15 (4)

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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	PLACE OF DEATH	STEVEN:			2	. USUAL RESIDENCE (lived, if instituti	an: Residence b	efore admis	sion)
C	Carrol	1		MARYLAN	D	o. STATE Maryla	nd	Bal	timore	City	/
b	. CITY OR TOWN (I	f autside carporate lim	its,	c. LENGTH OF STAY IN 15) (CITY OR TOWN (If a	utside corparate	limits, write RUR	AL and give ne	orest tawn)	-
	Sykesy	give nearest tawn)		Smo oda		Baltim	0.79			3 -	4
d		AL OR INSTITUTION (If I	nat in haspital,		(. STREET ADDRESS				e. IS RE	SIDENCE
		field Stat				283h M	aryland	Avenue		YES _	FARM?
3. N	NAME OF		irst	Middle	- 11	Last	4. DATE	Mant		Day '	Year
	DECEASED Type or print)	RA'	YMOND C	HESTER HII		r.	OF DEATH	Jul			9 66
S. S	SEX	6. COLOR OR RACE	7. MARRIED	NEVER MARRIED	8.	DATE OF BIRTH		GE (In years ast birthday)	Months De	AR IF UND	DER 24 HRS. Min.
	Male	White	WIDOWED	DIVORCED [7-22-94		71 yrs.	Months D	145	3 MIIII.
0o.	USHAL OCCUPATION	(Give kind of work dan		IND OF BUSINESS OR		11. BIRTHPLACE (County	& State, or fareig	n cauntry)		N OF WHAT	
urig	ng most of warking	(retired)	18	NDUSTRY		New Y	ork		COUNT	S.A.	
	FATHER'S NAME	(Le otted)			1	A. MOTHER'S MAIDEN			, ,	all a Cina	(A)
	37	77.33				A 2-7-2 2	- Van Ma	44.00			
15	WAS DECEASED EVE	RINU.S. ARMED FORCES	2 16	SOCIAL SECURITY NO.	17. INF	Adelaid	e vanga	Addre	ss		
(Yes	s, na, or unknawn)	(If yes give wor or dotes	of service)					CL.L.	17 2 do	. 7	
				nknown	reco	rds, Spri	ngilela	State	HOSPIL		CTIVEEN.
	18. CAUSE OF DE	ATH (Enter only one co								ONSET AND	DEATH
	1/ -	IMMEDIATE CAUS	E (o) Car	cinoma of lu	ıng	12.7%				PROTE	110
	16		E TO								
4	Conditions, if any,		(b)								
	stoting the under		E TO								
4	last.)	(c)								
_	PART II. OTHER SI	GNIFICANT CONDITIONS	CONTRIBUTING	TO DEATH BUT NOT RELATED	D TO THE	TERMINAL DISEASE CO	NDITION GIVEN I	N PART 1(o)	201-54	19. WAS AL	UTOPSY
2	CDS acen	artith anna	honol	rteriosclero	noie	whth neve	hotic r	eaction		YES	NO T
CEKTIFICATION	20g. ACCIDENT WA		20b. DI	ESCRIBE HOW INJURY OCCUP	RRED. (En	er nature of injury in	Port 1 or Port II	of item 18.)			
2	OR CONTRIBUTING	☐ CAUSE OF DEATH									
	,	MEDICAL EXAMINER) JRY Manth, Day, Year	20d. I	NJURY OCCURRED 200	e. PLACE	OF INJURY (Hame, farr	n. 20f. (City or town)	(County	()	(Stote)
MEDICAL	Hour a.r	n.	While	Not While		street, affice bldg., etc.			75. P.		
	p.r		at war	nded the deceased fra		-18-66	10 4-	TanlerO	1056	that (I)	(ma) la
				nded the deceased tra 19 . and			19, 10_	fram causes	and an the	data stat	(we) id
		eceased alive an_	1-3-0		i iliui c	edili decolled d	m,	ituiti tuuses	22b. DATE		eu ubuv
	22a. SIGNATURE	Eduardo	R.a	els		ATTENDING	MED.	STAFF PHYS.	- 7 0		
			/(M.D.	PHYS. L				ot + n1	
	22c. PHYSICIAN'S NAME (Type	1	5 1 5	27 5							
		80002100					ykesvil				
3a	BURIAL, CREMATIC		HEREOF	23c. NAME OF CEMETER	Y OR CRI	MATORY		TION (City or To		ounty)	(Stote)
	REMOVAL (Specify Burial	7/13	/66	Woodlawn Co	emet			imore,			
	. FUNERAL DIRECTO	R		ADDRESS			D BY REGISTRAR		GISTRAR'S SIGN	ATURE	,
Wn	. Cook-E	rooks Inc.	. 1217	St. Paul St.	212	02 DATE	JUL 13	1966	Milian	Ces fu	age

VR A15 (4) 20 M 1/66

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the ottending physical and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please, whove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, crematian, or removal, and in any event, within 72 haurs after death.

1617334 IN SECTION A Laborato Comple a series in god dhay obleteber 1 Assembly the State of Santa Market State of Santa S Testing Ind 2 big to the Sales Company of the Sales of t LE CHINES SAUCH BUSIN MARYLAND STATE DEPARTMENT OF HEALTH

THE MATTER TECHNISHED IN 25th W. R. LEWIS CO. LEWIS CO. LEWIS CO., LANSING, MICH. LANSING, MICH. LANSING, MICH. CONTRACTOR OF THE PROPERTY OF THE PARTY OF T SETURE. AND STREET STREET STREET STREET Education of the other with the large brett partie servered Residence Grant and arrive and a state of the common and a state of the common and the comm A CANALA Control of the second

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

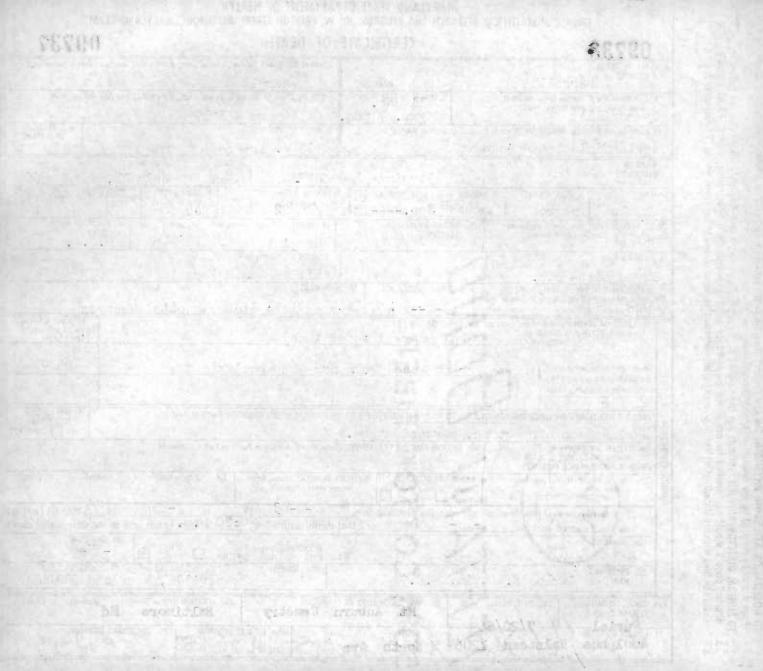
(1973)

1. PLACE OF DEATH	2. USUAL RESIDENCE (Where deceased lived, If institution: Re	esidence before admission)
a. COUNTY CALROLL MARYLAND	a. STATE MARYLAND b. COUNTY CA	RROLL
b. CITY OR TOWN (if outside corporate limits. c. LENGTH OF STAY IN 1h	c. CITY OR TOWN (If outside corporate limits, write RURAL and	
Write RURAL and give nearest town)		
LOKAL LINKSION IN	RURAL, FINKSBURG	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give streat address)	d. STREET ADDRESS	e. IS RESIDENCE ON A FARM?
		YES NO
3. NAME OF First Middle DECEASED	Last 4. DATE Month	Day Year
(Type or print) £LVIE MAUDE	HUGHES DEATH JULY	19 1966
5. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED	B. DATE OF BIRTH COLL 9. AGE (In years IF UNDER 1)	YEAR IF UNDER 24 HRS.
WIDOWED THE DIVORCED TO	DUNE 14, 1894 9. Age (In years lest birthday) Months D	ays Hours Min.
10a. USUAL OCCUPATION (Give kind of work 10b. KIND OF BUSINESS OR INDUST	TRY 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZ	ZEN OF WHAT COUNTRY?
done during most of working life, even if retired)		SA.
13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME	.011,
FRANK E. HARRY	14. MOTHER'S MAIDEN NAME	100
	CLARA E, STRICK	LER
15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. (Yes, no, or unkown) (Ifyesgivewarordatesofservice)	INFORMANT	
No - 216-38-2554 A	Trong C' Hership Impopura	RTAZMI.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]	140-100-1	INTERVAL BETWEEN
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CELEBRAL TH	RAM BOSIS	SAND DEATH
332X DUE TO	15.772 - (2)	
Conditions, if any, which \ (b) GENERALIBED	ALABRIASCLEROCIS	10 YAS
gave rise to immadiate cause	111011901000000000000000000000000000000	
(a), stating the underlying DUE TO DIASETES ME	11715	STRS
(c)		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT N	OT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1	1(a) 19. WAS AUTOPSY PERFORMED?
5 CALCINOMA OF BLADDEC	142	YES NO
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT N CALCINOMA DE BLADDEL 208. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH OF CONTRIBUTING CO	RED. (Enter nature of injury in Part I or Part II of item 18.)	
(IF EITHER, NOTIFY MEDICAL EXAMINER)		
20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PL	ACE OF INJURY (Home, farm, † 20f. (City or town) (Count	ty) (State)
	ctory, straat, offica bldg., etc.)	
	1/25 000 7/1000	4
21. I certify that (I) (this hospital) attended the deceased from		that (I) (we) last
saw the deceased alive on	death occurred at	date stated above.
22a. SIGNATURE	ATTENDING MED STAFF	22b. DATE
	M.D. PHYS. DIRECTOR PHYS.	7/19/66
22c. PHYSICIAN'S NAME (Type) WILLIAM / STELLIA TA	22d. ADDRESS	1 4 14 2
NAME (Typo) WILLIAM L. STEWART,	10 19 RIDGE RD. WESTMINST.	KKITI,
	OR CREMATORY 23d. LOCATION (City, town or county)	(Stata)
BANOVAL (Specify) M/22/66 Promoder	use Cemite Findostura Ri	THI md
24 FUNERAL DIRECTOR'S SIGNATURED ADDRESS	25a, REC'D BY REGISTRAR 25b, REGISTRAR'S SI	GNATURE
4.2. mules b. westnessoto.	me / 1111 22 than me	
L'indicate l'indication	Ma . DATE JUL & DOB JULIA	rug judge

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH requires that the death certificate be executed within 24 hours after death onde filled in by the funeral papers. Pages 1 and 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) PLACE OF DEATH a. COUNTY o. STATE b. COUNTY Carroll Maryland cremation, or removol, and in any event, within 72 hours after MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURA), and give neorest town) c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 21217 ykesvi mos and completely filled in tremove carbon papers. e. IS RESIDENCE ON A FARM? d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d STREET ADDRESS Springfield State Hospital 915 N. Freemont Avenue YES NO X 3. NAME OF First Middle 4. DATE Month Last Year DECEASED HYMAN Helen Virginia Lee July 19 66 DEATH (Type or print) IF UNDER 24 HRS. IF UNDER 1 YEAR S. SEX DATE OF BIRTH 9. AGE (In years 6. COLOR OR RACE 7. MARRIED NEVER MARRIED Jost birthday) Months Dovs Hours 5/11/22 Sep DIVORCED IX female WIDOWED negro 10o. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & Stote, or foreign country) 12. CITIZEN OF WHAT INDUSTRY COUNTRY? offending physician operation Virginia 14. MOTHER'S MAIDEN NAME 13. FATHER'S NAME Willie Mae Peters Rufus Lee - dec. 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address (Yes, na, ar unknawn) (If yes give wor ar dates of service 213-29-6646 Springfield State Hospital Records per INTERVAL BETWEEN 1B. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).) signed by the burial-tronsit p ONSET AND DEATH PART I. DEATH WAS CAUSED BY Pulmonary insufficiency IMMEDIATE CAUSE (o) **DUE TO** Years Canditions, if ony, which gave (b) Far advanced Pulmonary Tuberculosis rise to immediate couse (o). DUE TO stoting the underlying cause Page 4 may be retained by the hospital or attending os the prior to has been lost. 19. WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) be detached for use State Dept. of Health Schizoph enic reaction, paranoid type. NO O FUNERAL DIRECTOR: After this certificate director, page 3 should be detached for us 20g. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II af item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, (City or town) (County) (State) 20c. TIME OF INJURY Month, Doy, Yeor foctory, street, affice bldg., etc.) Hour a.m Not While ot wark at work 19 00, that (I) (we) last 21. I certify that (I) (this haspital) attended the deceased fram. plnods and that death accurred at 8:20 M from causes and an the date stated above. saw the deceased alive on 5-00 19 22b. DATE SIGNED 220. SIGNATURE STAFF PHYS. DIRECTOR M.D. PHYS director, poge 3 should be filed ed Springfield State Hospital -22c. PHYSICIAN'S 22d. ADDRESS Carlos G. Lavin, M.D. Sykesville, Maryland 21784 NAME (Type) 23c. NAME OF CEMETERY OR CREMATORY

Mt Auburn Cemetry 23d. LOCATION (City or Town)

Baltimore 23o. BURIAL, CREMATION, 23b. DATE THEREOF (County) (Stote) REMOVAL (Specify) 25o. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE ADDRESS VR A15 (4) 20 M 1/66



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 1203 09733 CERTIFICATE OF DEATH deoth. 2 The law requires that the death certificate be executed within 24 hours after death the ottending physicion and completely filled in by the funeral sit permit. Then please remove carbon papers. Pages I and 2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission) PLACE OF DEATH o. COUNTY Carroll Baltimore City within 72 hours after MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 1b. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 9mos.ldv. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street oddress) d. STREET ADDRESS IS RESIDENCE ON A FARM? 1135 Parrish St. Springfield State Hospital NO TX YES 3. NAME OF 4. DATE First Middle Month Dov Year DECEASED WILLIAM ERNEST JAMES JULY 23 66 19 (Type or print) DEATH IF UNDER I YEAR IF UNDER 24 HRS. S. SEX 8. DATE OF BIRTH AGE (In years 6. COLOR OR RACE 7. MARRIED NEVER MARRIED Jast birthdoy) Hours Negro Male 10-30-1894 WIDOWED DIVORCED 10b. KIND OF BUSINESS OR 12. CITIZEN OF WHAT 10o. USUAL OCCUPATION (Give kind of work done 11. BIRTHPLACE (County & Stote, or foreign country) during most of working life, even if retired) COUNTRY? INDUSTRY Unemployed Virginia U.S.A 14. MOTHER'S MAIDEN NAME 13. FATHER'S NAME Unk. Unk. 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 17. INFORMANT 16 SOCIAL SECURITY NO. (Yes, no ar unknown) (If yes give war or dates of service) 212-26-7178 Records, Springfield State Hospital CAUSE OF DEATH (Enter only one couse per line for (o), (b), ond (c).)
PART I. DEATH WAS CAUSED BY: INTERVAL BETWEEN ONSET AND DEATH buriol-transit Carcinoma of the lung IMMEDIATE CAUSE (o). signed by **TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires the Poge 4 may be retained by the hospitol or attending physician. DUE TO Conditions, if ony, which gove rise to immediate couse (a). DUE TO stoting the underlying couse TO FUNERAL DIRECTOR: After this certificate hos been lost. 19. WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) for use NO X 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 1B.) 20o. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH detached (IF EITHER, NOTIFY MEDICAL EXAMINER 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, (City or town) (County) (Stote) 20c. TIME OF INJURY Month, Doy, Year foctory, street, office bldg., etc.) Not While of work 21. I certify that (I) (this haspital) attended the deceased fram 10-22-65 19015ta 7-23-66 , 19 , that (1) (we) last saw the deceased alive an 7-23-66 _______, and that death accurred at M. fram causes and an the date stated above. 22b. DATE SIGNED 22o. SIGNATURE MED. DIRECTOR STAFF PHYS. 7-25-66 M.D. Springfield State Hospital 22d. ADDRESS 22c. PHYSICIAN'S Octavio A. Ruiz. NAME (Type) Sykesville. Maryland 232) NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (County) (Stote) 23o. BURIAL, CREMATION, 23b. DATE THEREOF REMOVAL (Specify) 250. REC'D BY REGISTRAR 2Sb. REGISTRAR'S SIGNATURE 24. FUNERAL DIRECTOR

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MARYLAND STATE DEPARTMENT OF HEALTH

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH 09741 deoth, requires that the death certificate be executed within 24 hours after death. filled in by the funeral papers. Pages 1 and PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. COUNTY o. STATE h. COUNTY Carroll MARYLAND c. CITY OR TOWN (if outside corporate limits, write RURAL and give neorest town) ve carbon papers. Pages 1 event, within 72 hours after b. CITY OR TOWN (If outside corporate limits, c. LENGTH OF STAY IN 16 write RURAL and give nearest tawn) Sykesville Cumberland e. IS RESIDENCE ON A FARM? d. NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) d. STREET ADDRESS Springfield State Hospital 12 YES NO IX 725 KOTTT Rlvd NAME OF Middle remove carbon Inst 4 DATE Manth First Doy Year DECEASED July 1956 . Kollou (Type or print) Joseph William DEATH IF UNDER 24 HRS. S. SEX 6. COLOR OR RACE DATE OF BIRTH AGE (In years IF UNDER 1 YEAR NEVER MARRIED 7. MARRIED last birthday) Manths Dovs Haurs Male WIDOWED DIVORCED TV 7-27-77 10a. USUAL OCCUPATION (Give kind of wark dane during mast af working life, even if retired) 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or fareign country) 12. CITIZEN OF WHAT INDUSTRY COUNTRY? attending physicion permit. Then please Contr. Cumberland Electrician 14. MOTHER'S MAIDEN NAME 13. FATHER'S NAME or removo Lucy Violet Kerns John Joseph Kelley WAS DECEASED EVER IN U.S. ARMED FORCES? 17. INFORMANT Address 16. SOCIAL SECURITY NO. permit. (Yes, no, or unknown) (If yes give wor or dates af service) Hospital Record. Svkesville. 220-10-1364 es. INTERVAL BETWEEN 1B. CAUSE OF DEATH (Enter only one cause per line for (o), (b), and (c), buriol-tronsit PART I. DEATH WAS CAUSED BY ONSET AND DEATH Right Ventricular failure IMMEDIATE CAUSE (a) physicion. Chronic Pulmonary insufficiency DUE TO signed l Conditions, if any, which gave ears rise ta immediate cause (a), DUF TO stating the underlying couse Poge 4 may be retoined by the hospital or attending O FUNERAL DIRECTOR: After this certificate has been TB for use os the Old last 19. WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) CERTIFICATION Alcoholic Addiction YES T NO 20g. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port 1 or Part II of item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20e. PLACE OF INJURY (Hame, farm, (City or town) (State) 20c. TIME OF INJURY Manth, Day, Yeor 20d. INJURY OCCURRED 20f. (Caunty) Haur o.m. factory, street, affice bldg., etc.) Nat While at wark 21. I certify that (I) (this haspital) attended the deceased fram July 8 , 1966, ta July 9 , 19 66 that (I) (we) last and that death accurred at 11:00M, from causes and an the date stated above saw the deceased alive an -9-66 19 22b. DATE SIGNED 22a. SIGNATURE ATTENDING X M.D. PHYS DIRECTOR PHYS. director, poge 3 should be filed 22c. PHYSICIAN'S 22d. ADDRESS NAME (Type) Sykesville, Maryland 23d. LOCATION (City or Tawn) 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY (Stote) 23a. BURIAL CREMATION. (County) BREMOYAL (Specify) 7/13/66 SS. Peter & Paul Cem. Cumberland, Allegany 2Sb. REGISTRAR'S SIGNATURE ADDRESS 2Sa. REC'D BY REGISTRAR 24. FUNERAL DIRECTOR Charley H. Wayne George Cumberland, Maryland 1966

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2	DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND OPEN 19742 CERTIFICATE OF DEATH
14 M	2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE ARROLL MARYLAND 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) b. COUNTY a. STATE MARYLAND
fer deaf	b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Widdlebiurg b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Manches Ter.
Ponts a	d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) BROOK FIELD Manor Nurs. Home d. STREET ADDRESS e. 15 RESIDENCE ON A FARM? YES \(\sum \no \text{NO} \)
thin 72	3. NAME OF DECEASED (Type or print) George Modele Last 4. DATE Month Day Year OF DEATH 7 21 19 66 5. SEX 6. COLOR OR RACE T MARRIED NIEVER MARRIED 18. DATE OF BIRTH 19. AGE (In years If UNDER 1 YEAR) IF UNDER 24 HRS.
ent wi	Male When the work 100. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (County & State, or loreign country) 12. CITIZEN OF WHAT COUNTRY?
any ev	done during most of working life, even if relired) Carrol Co. Md. 21 Sa. 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME
u pue	Charles W. Leese Jane Hale 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address
moval	(Yes, no, or unkown) (Ifyesgive war or dates of service) 218-32-4517 Mr. Harry Leese, Welley View, Verna.
n, or re	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ONSET AND DEATH SCHOOL OF CASEN (C).
rematio	Conditions, if any, which are iso to immediate cause (b) Crebral atthews solvers is '
ourial, c	(a), stating the underlying DUE TO cause last. (c)
ior to	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY PERFORMED? YES NO
adith pr	20a. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month Day Year 20d INJURY OCCURED 20e. PLACE OF INJURY (Home, farm, ' 20). (City or town) (State)
of H	Hour a.m. While Not While lactory, street, ollice bldg., etc.) p.m. 19 at work at work
ate Dep	21. I certify that (I) (this hospital) attended the deceased from 7 19 46 19 19 16 19 19 19 19 19 19 19 19 19 19 19 19 19
the St	228 SIGNATUR ATTENDING MED. STAFF PHYS. DIRECTOR PHYS. D 229. DATE SIGNED 220. ADDRESS 220. ADDRESS
for, pag	NAME (Type)
P P P	236. BURIAL, CREMATION, 236. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) (State) REMOVAL (Specify) 7/1-3/66 AMMEDIAN CEMETERY OF CREMATORY 23d. LOCATION (City, town or county) (State) THE COUNTY OF THE COUNTY SIGNATURE ADDRESS 250. REC'D BY REGISTRAR 256. REGISTRAR'S SIGNATURE
A15 (4) N M 7-62	Jipton - Eline. Hampstead, Md. Date JUL 26 1966 Icharles Jusque

MARYLAND STATE DEPARTMENT OF HEALTH

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DIVISION OF STATISTICAL RESEARCH AND RECORDS. 301 PRESTON STREET, BALTIMORE 1, MARYLAND RTIFICATE OF DEATH funeral 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before edmission) a. COUNTY b. COUNTY MARYLAND b. CITY OR TOWN (if outside corporate limits c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL and give neerest town) write RURAL and give nearest town) ancheste d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street eddress) IS RESIDENCE d. STREET ADDRESS ON A FARM? 15179 YES NO completely 3. NAME OF Middle 4. DATE Month Day Yeer DECEASED OF (Type or print) DEATH 19 66 and cor carbon nt, withir 5. SEX 9. AGE (In years | IF UNDER 1 YEAR OR RACE 7. MARRIED NEVER MARRIED IF UNDER 24 HRS. last birthday) Months | Days Hours WIDOWED DIVORCED 10a. USUAL OCCUPATION (Give kind of work 12. CITIZEN OF WHAT COUNTRY? 10b. KIND OF BUSINESS OR INDUSTRY BIRTHPLACE (County & State, or foreign country) done during most of working life, even if retired) 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 1 17. INFORMANT (Yes, no, or, unkown) | (If yes give war or detes of service) tinks bulg 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), end (c). INTERVAL BETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED BY: 6 ma IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate causa DUE TO (e), stating the underlying cause lest. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(4) 19. WAS AUTOPSY CERTIFICATION PERFORMED? NO V 20e. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURED, (Enter neture of injury in Pert I or Pert II of item 18.) OR CONTRIBUTING [] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) MEDICAL 20d. INJURY OCCURRED I 20e, PLACE OF INJURY (Home, farm, 20c. TIME OF INJURY Month, Day, Year 20f. (City or town) (County) (Stete) Not While factory, street, office bldg., etc.) Whila Hour a.m. at work et work 19 p.m. 19....., and that death occured at ... I.M. from the causes and on the date stated above. saw the deceased alive on. 22b. DATE 22a. SIGNATURE ATTENDING MED SIGNED STAFF PHYS. PHYS. DIRECTOR 22d. ADDRESS 22c. PHYSICIAN'S NAME (Type) 23d. LOCATION (City, town or county) NAME OF (Stata) 23a. BURIAL CREMATION. REMOVAL (Specify) SULIA RECAD BY REGISTRAR 256. REGISTRAR'S SIGNATURE 24 FUNERAL DIRECTOR'S SIGNATURE VR A15 (4) Charles 15M 7 61

OF HEALTH

RYLAND STATE DEPARTMENT OF HEALTH PRESTON STREET, BALTIMORE 1, MARYLAND DIVISION OF STATISTICAL RESEARCH AND RECORDS. CERTIFICATE OF DEATH funeral Home and 2. USUAL RESIDENCE (Where deceased lived, If Institution, Residence before edmission PLACE OF DEATH b. COUNTY the day MARYLAND adams b. CITY OR TOWN (if outside corporate limits. c. LENGTH OF STAY IN 16 OR TOWN (If outside corporete limits, write RURAL end give neerest town) write RURAL and give nearest town) NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street eddress d. STREET ADDRESS IS RESIDENCE ON A FARM? YES NO complete NAME OF DATE 3per 72 Month Day Year DECEASED OF (Type or print) DEATH 196 5. SE) 6. COLOR OR RACE 7. MARRIED NEVER MARRIED AGE (In years | IF UNDER 1 YEAR IF UNDER 24 HRS DATE OF BIRTH 9. last birthday) Months Days Hours Min. 8/3/1888 WIDOWED DIVORCED 10e. USUAL OCCUPATION (Give kind of work 10b. KIND OF BUSINESS OR INDUSTRY 12. CITIZEN OF WHAT COUNTRY? (County & State, or foreign country) done during most of working life, even if retired The Family Home 14. MOTHER'S MAIDEN NAME 13. FATHER'S NAME Hook raru 15. WAS DECLASED EVER IN U.S. ARMED FORCES? SOCIAL SECURITY NO. 17. INFORMANT Address (Yes, nor unkown) | (If yes give we ror detes of service) Rodney P. Neiderer, Hanover, Pa. R. D. 4 18. CAUSE OF DEATH [Enter only one cause per line for (e), (b), end (c).] INTERVAL BETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) DUE TO ancer- T achurmana Conditions, il eny, which gave rise to immediate causa DUE TO (a), steting the underlying cause last. PART II, OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY CERTIFICATION PERFORMED? NO P use 20b. DESCRIBE HOW INJURY OCCURED. (Enter neture of injury in Pert I or Pert II of item 18.) 20e. ACCIDENT WAS UNDERLYING TI OR CONTRIBUTING CAUSE OF DEATH ained by R: After 1 (County) (State) 20c. TIME OF INJURY Month, Dev. Year 20d. INJURY OCCURRED 20e, PLACE OF INJURY (Home, ferm, 20f. (City or town) fectory, street, office bldg., etc.) While Not While MEDI Hour e.m. CTOR: et work et work p.m 21. I certify that (I) (this hospital) attended the deceased from. to...... and that death occured and 2.M. from the causes and on the date stated above. saw the deceased alive on. nay b DIRE(3 22a. SIGNATURE 22b. DATE ATTENDING SIGNED STAFF Page FUNERAL irector, page 3 DIRECTOR PHYS. PHYS. M.D. 22d. ADDRESS 22c. PHYSICIAN'S NAME (Type) - Hampstead, Md. 23d. LOCATION (City, town or county) 23a. BURIAL, CREMATION, | 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY OF Burial Nr. Littlestown, Adams Co. Pa. 7/21/66 Christ Church Cemetery 250. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE FUNERAL DIRECTOR'S SIGNATURE VR A15 (4) 15M 7/61

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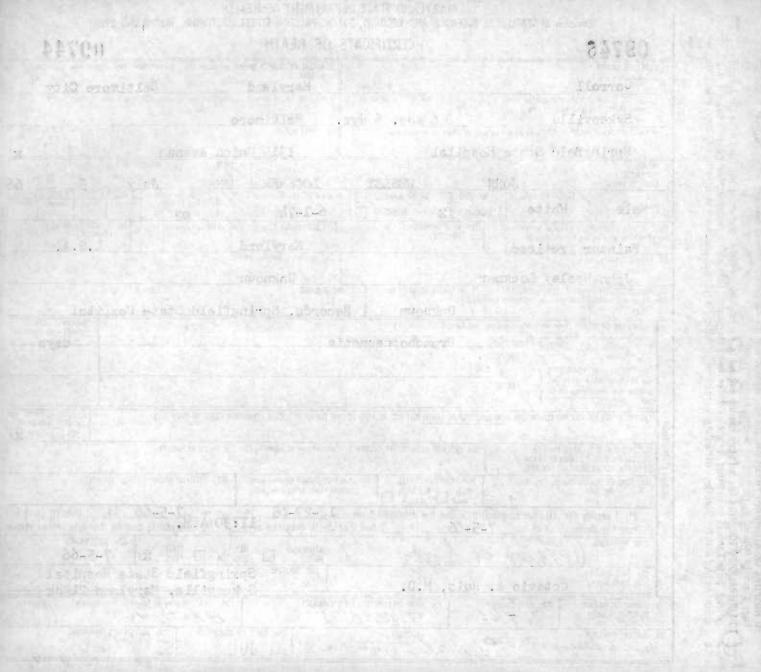
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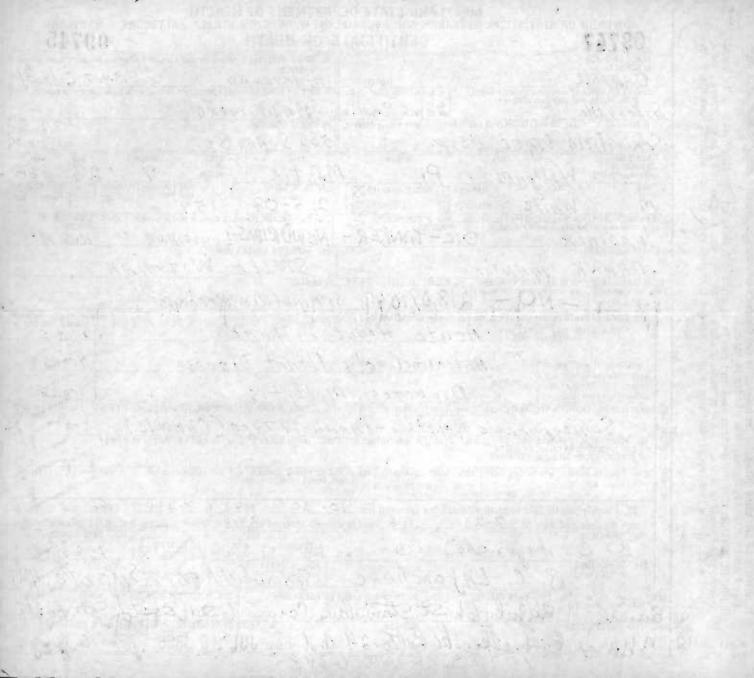
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MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH 09746 requires that the death certificate be executed within 24 haurs after death death and campletely filled in by the funeral remove corbon papers. Pages 1 and 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. COUNTY a. STATE b. COUNTY Maryl and MARYLAND Baltimore City C. LENGTH OF STAY IN 16 c. CITY OR TOWN (If autside corporate limits, write RURAL and give nearest town) b. CITY OR TOWN (If autside carparate limits, write RURAL and give neorest town)

Sykesville 6 mos. 6 dvs Baltimore d. NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? ond in any event, within 72 NO Springfield State Hospital 1315 Union Avenue YES 3. NAME OF Middle 4. DATE Month Last Day Year DECEASED July FUNDER 1 YEAR Days JOHN LOCKNER (Type or print) WESTEY DEATH IF UNDER 24 HRS AGE (In years last birthday) S. SEX 6. COLOR OR RACE B. DATE OF BIRTH 7. MARRIED NEVER MARRIED Hours Male White 130 6-1-74 WIDOWED DIVORCED 10a. USUAL OCCUPATION (Give kind of work done 11. BIRTHPLACE (County & State, or foreign country) 10b. KIND OF BUSINESS OR 12. CITIZEN OF WHAT COUNTRY? during most of working life, even if retired) INDUSTRY Maryland Painter (retired) 14. MOTHER'S MAIDEN NAME 13. FATHER'S NAME John Wesley Lockner Unknown 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT (Yes, no, or unknown) (If yes give war or dotes of service) 0 Records. Springfield State Hospital No Unknown INTERVAL BETWEEN IB. CAUSE OF DEATH (Enter only one cause per line far (a), (b), and (c).) signed by the buriol-transit p ONSET AND DEATH PART I. DEATH WAS CAUSED BY Bronchopneumonia days IMMEDIATE CAUSE (o). DUF TO Conditions, if any, which gave rise ta immediate couse (a). DUE TO as the prior tak stating the underlying cause TO HOSPITAL OR ATTENDING PHYSICIAN: The law re Page 4 may be retained by the hospital or attending TO FUNERAL DIRECTOR: After this certificate has been 19. WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) MEDICAL CERTIFICATION NO E far 20a. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I ar Part II of item 1B.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20d. INJURY OCCURRED 20e, PLACE OF INJURY (Hame, farm, 20f. (City or town) (County) (Stote) 20c. TIME OF INJURY Manth, Day, Year factory, street, office bldg., etc.) Nat While at wark at work 21. I certify that (I) (this haspitol) attended the deceased from_ 12-29-65 7-5-66 .. 19 .. that (I) (we) lost saw the deceased alive an 7-5-66 19 and that death occurred all:30 M. from causes and on the date stated above. 22a. SIGNATURE 22b. DATE SIGNED STAFF PHYS. ATTENDING K 7-5-66 DIRECTOR M.D. PHYS director, page shauld be filed 22d, ADDRESS Springfield State Hospital 22c. PHYSICIAN'S NAME (Type) Octavio A. Ruiz, M.D. Sykesville, Maryland 2178h 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (State) 23b. DATE THEREOF 23a. BURIAL CREMATION. REMOVAL (Specify) ST. MARY'S BALTO, MO. 2Sb. REGISTRAR'S SIGNATURE 2So. REC'D BY REGISTRAR 24. EUNERAL DIRECTOR Cant E Cherowell 3al 1966



	1	MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1,	MADVIAND
for	£ = ~	09747 CERTIFICATE OF DEATH	09745
	after death. the funeral ges 1 and 2 after death.	1. PLACE OF DEATH a. COUNTY CARROLL MARYLAND 2. USUAL RESIDENCE (Where deceased lived, If Institution a. STATE b. COUNTY MARYLAND MARYLAND	1: Residence before admission) ALT, City 31
	ours aft in by the Pages iours af	b. CITY OR TOWN (if outside corporate limits, write RUF STAY IN 1b c. CITY OR TOWN (if outside corporate limits, write RUF SYKes ville 22 YRS. 9 months BALTIMER C	RAL and give nearest town)
	24 hours filled in b papers. Pain 72 hours	d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS SPRINGFIELD STATE HOSP. 502 S-ANN St.	e. IS RESIDENCE ON A FARM? YES NO
	executed within 24 hours after and completely filled in by the remove carbon papers. Pages namy event, within 72 hours aft	3. NAME OF First Middle Last 4. DATE Month OF OF OF DEATH 7	Day Year 23 1966
	and con remove any eve	5. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 8. DATE OF BIRTH 9. AGE (in years last birthday) Mhite Widowed Divorced 2.5-09 5.7 yrs.	DER 1 YEAR IF UNDER 24 HRS. 18 Days Hours Min.
		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER 10b. KIND OF BUSINESS OR INDUSTRY OLTHORER - NEWDRIAMS LOWIS IANA 11. BIRTHPLACE (County & State, or foreign country) 12.	COUNTRY?
	ath certificate be attending physician rmit. Then please n, or removal, and t	13. FATHER'S NAME FRIANK MANTIK STELLA WOZMIAK	
	attend ermit.	15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address (Yes, no, or unknown) (Ifyes give war or dates of service) 218,091649 SPRINGFIELD RECORDS	
	law requires that the death certificate be trending physician. has been signed by the attending physician as the burial-transit permit. Then please prior to burial, cremation, or removal, and	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Heart Failure	INTERVAL BETWEEN ONSET AND DEATH
	aw requires that ttending physician has been signed I as the burial-trai prior to burial, cr	Conditions, If any, which gave rise to immediate (b) ARTERIOSCLEROTIC HEART Discase	Years
	aw required tending las beer as the prior to	cause (a), stating the DUE TO Diabetes Mellitis	Years (a) 119. WAS AUTOPSY
		Schizophrenic Reaction - PARANDIN TYPE (CHRONIC)	PERFORMEO? YES NO
	PHYSICIAN: The the hospital or a this certificate detached for use Dept. of Health		
	d by the After the d be det	Hour a.m. p.m. Hour a.m. While Not While at work at work factory, street, office bldg., etc.)	(County) (State)
		saw the deceased alive on 7-23 1966, and that death occurred a 3.45 A.M., from the causes and o	n the date stated above. DATE SIGNED
	OR DIRE	22a. SIGNATURE R. C. Jajonalee M.D. ATTENDING MED. STAFF 22c. PHYSICIAN'S DIRECTOR PHYS. 22d. ADDRESS	7-23-66
	O HOSPITAL Page 4 may O FUNERAL I director, pa	NAME (Type) R. C. LAjonchere Springtield Hosp. Jyk	county) (State)
	of of particular of the state o	REMOVAL (Specify) Bound Can Con Con Con Con Con Con Con	St. Batto
	VR AI5 (4) 20M 1/65	Marie & Healkeville Balton 24 mg DATE JUL 26 1966 gold	arles Judge



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100	MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE	1 MADVIAND
3	09750 CERTIFICATE OF DEATH	09748
1.	a. COUNTY a. STATE b. COUNTY	tion: Residence before admission
-	b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) C. LENGTH OF STAY IN 1b C. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	RURAL and give nearest town
1	d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS	e. IS RESIDENCI
	23 Park and . 23 Park and .	ON A FARM? YES NO
3.	NAME OF DECEASED (Type or print) NOERNER Middle MC KINSEY 4. DATE OF OF DEATH SEALANT	Day Year 19 66
5.	SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 8 DATE OF BIRTH 9. AGE (In years IF)	UNDER 1 YEAR IF UNDER 24 HR
10a dur	Da. USUAL OCCUPATION (Give kind of work done Industry) Industry Industry	12. CITIZEN OF WHAT COUNTRY?
13.	3. FATHER'S NAME 14. MOTHER'S MAIDEN NAME. 7	u.s.a.
15	5. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITYNO. 17. INFORMANT Address	an
(Ye	(es, no, or unkown) (If yes give war or dates of service) 067 - 09-9513 Mrs Wolmer Mc Kins	ey address
	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	INTERVAL BETWEEN ONSET AND DEATH
	5 271 DUE TO	17
	Conditions, if any, which gave rise to immediate cause (a), stating the DUE TO	1 1 gun
NOI	underlying cause last.) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART	RT 1(a) 19. WAS AUTOPSY PERFORMED?
CERTIFICATION	Certerioschentic Heart Dusase · Cerebral Vascular Janficia	YES NO
		eim 18.)
MEOICAL	20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED thour a.m. 20d. INJURY OCCURRED factory, Street, office bldg., etc.) while at work at work at work at work at work at work	(County) (State)
	21 partify that (1) (this hospital) attended the decorate from 1062 to July (19 66, that (I) (we) las
H	saw the deceased alive on July 1966, and that death occurred at 4 7 M, from the causes and 22a. SIGNATURE	d on the date stated above 2b. DATE SIGNED
	22c. PHYSICIAN'S M.D. ATTENDING MED. STAFF PHYS. 22d. ADDRESS	7/1/60
	NAME (Type) JOHN S. HARSHEY M.D. 8 auchon St. West	wenster had
23a	Ba. BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town BEMOVAL Specify)	or county) (State)
24	CLS much b. bottomette med III 5 1000	STRAR'S SIGNATURE
4	2. 1. Joseph John Marie Just Date Of J 1808	marley Judge

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND FOR STATE MEDICAL EXAMINER'S CERTIFICATE OF DEATH HEALTH DEPT 1. PLACE OF DEATH e. COUNTY 2. USUAL RESIDENCE (Where deceased lived, If Institution; Residence before admission) a. STATE b. COUNTY Carroll MARYLAND Maryland Department after death. funeral may be b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 1b Sykesville Days Silver Spring the 5 d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) e. IS RESIDENCE d. STREET ADDRESS ON A FARM? 3 to 1 State hours a 12 Springfield State Hospital 2607 Glenallen Ave YES Z NO . any dela 2, and PM3. F NAME OF First Middle Lest 4. DATE Month Yeer DECEASED OF Elizabeth DEATH (Type or print) Anna McQuin 19 2 with within 6. COLOR OR RACE | 7. MARRIED | NEVER MARRIED AGE (In Years I F UNDER 1 YEAR IF UNDER 24 HRS DATE OF BIRTH 8. last birthday) | Months | Days Hours Female White WIDOWED -DIVORCED [and event 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) INDUSTRY 12. CITIZEN OF WHAT COUNTRY? 11. BIRTHPLACE (State or foreign country) -Housewife. 18. Gi along pages 1 in any 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME Hnknown Dont Unknown Address Sykesville 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 17. INFORMANT 16. SOCIAL SECURITY NO. (Yes, no, or unkown) (If yes give war or dates of service) Springfield Hospital Record, Maryland EXAMINER: This certificate should be executed within certificate, writing the word "pending" in pencil and the forwarded to the Chief Medical Examings. INTERVAL BETWEEN ONSET AND DEATH 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c), PART I. DEATH WAS CAUSED BY: burial-transit eless IMMEDIATE CAUSE (a). cremation, DUE TO Conditions, if any, which gave rise to immediate DUE TO cause (a), stating the B underlying cause last used as to burial, WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH CERTIFICAT YES [NO V 20a. EXTERNAL CAUSE WAS PRIMARY [] OF CONTRIBUTING CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) the certificate, writing should be forwarded ll Dave WARD PA shoul 3 shou agent, MEDICAL (County) (State) 20d. INJURY OCCURRED | 20e. PLACE OF INJURY (Home, farm, 20f. (City or town) 20c. TIME OF INJURY Month, Day, Yeer factory, street, office bldg., etc.) Hour Not While ESVILLE While at work at work 21. I certify that I took charge of the remains described above, held an Autopsy Inspection X, Inquiry and in my opinion FUNERAL DIRECTOR: Suicide Homicide Undetermined manner death resulted from: Natural causes Accident X CHIEF MEDICAL EXAMINER X YOUR Page 4 22. DATE SIGNED ASSISTANT MEDICAL EXAMINER SIGNATURE for 0 DEPUTY MEDICAL EXAMINER **EXAMINER'S** director. Address (Street, City, town, by county) NAME (Type) W.Glenn 23d. LOCATION (City, fown or county) 23c. NAME OF CEMETERY OR CREMATORY BURIAL, CREMATION, 23b. DATE THEREOF 0 0 REMOVAL (Specify) Rockville Montgomery 25a. REC'D BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE 1331 Rockvillaporesske 24. FUNERAL DIRECTOR Charles Judge Rockville, Maryland Tyson Wheeler VR A15ME 3500 4-64

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1-1	MARYLAND STATE DEPARTMENT OF HEALTH
7 = =0=	DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH
funeral and ceath.	1. PLACE OF REATH e. COUNTY 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a STATE b. COUNTY
the the affer	b. CITY OR TOWN (If outside corporate limits. I. c. LENGTH DE STAY IN 1b. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
hours after d in by the rs. Pages A	Revial Westminuter 10 m. Rural Westminutes 06-1
24 hc filled apers. n 72 h	d. NAME DF HDSPITAL DR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS d. STREET ADDRESS ON A FARM? YES NOTE OF A CONTROL OF A CONTR
thin tely fi	3. NAME OF First Middle Lest 4. DATE Month Day Year
d wij	(Type or print) /
tecute and co	5. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 8. DATE OF BIRTH 9. AGE (14 years LEPHDER 1 YEAR IIF UNDER 24 HRS. Hours Min. WIDOWED DIVORCED 364, 14 190 2 644 yrs.
be excision a sise re	106. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10b. KIND DF BUSINESS OR 11. BIRTWPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT CDUNTRY?
icate be executed within 24 hours a physician and completely filled in by n please remove carbon papers. Pag val, and in any event, within 72 hours	13. FATHER'S NAME DE MOTER'S NAME DE MOTER'S NAME DE MOTER'S MAIDEN NAME
ertifica ding ph	Harry L. Groff. mary retta Little
law requires that the death certificate be executed within tending physician. has been signed by the attending physician and completely as the burlat-transit permit. Then please remove carbon prior to burlat, cremation or removal, and in any event, with	15. WAS DECEASED EVEN IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) 2/6-0/-6089 my Clayton 2 mylys, address
at the declar.	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
es that the hysician. signed by t urial-transit urlal, crema	PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Edema of lungs 2 hours about
physi n sign burial	Conditions, if any, which gave rise to immediate (b) Right heart failure cohorus
PHYSICIAN: The law requires that the hospital or attending physician. This certificate has been signed betached for use as the burlat-trans. Dept. of Health prior to burlal, cre	cause (a), stating the UE TO Colore of arcinoma is out matillary of and 9-65
CIAN: The law ospital or atten certificate has led for use as t. of Health price.	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTDPSY PERFORMED?
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0 -	20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
OR ATTENDING I y be retained by to OIRECTOR: After age 3 should be ciled with the State	21. I certify that (I) (this hospital) attended the deceased from, 19, 1966, that (I) (we) last
ATTEN retaine ECTOR: 3 shoul with the	saw the deceased alive on 7 - 3 1966, and that death occurred at 2 M, from the causes and on the date stated above. 22b. DATE SIGNED
	ATTENDING MED. STAFF 7-4-64 22c. PHYSICIAN'S 1 22d. ADDRESS
FIGURE OR ATTENDING Page 4 may be retained by TO FUNERAL DIRECTOR. After director, page 3 should be should be filed with the State	NAME (Type) C. L. Billingslea Westminslen, Md
Page To Fu	23a. BURIAL CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) (State)
(3)	24. FUNERAL DIRECTOR ADDRESS 25a. RECOUNT REGISTRAR'S SIGNATURE 25b. REGISTRAR'S SIGNATURE
VR A15 (4) 15M 4-64	J'z miers p - west misselve logare JUL 6 1966 gelarles Judge

DIVISION OF STATISTICAL RESEARCH ESTON STREET, BALTIMORE 1, MARYLAND OF DEATH funeral after PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before edmission) a. COUNTY a. STATE 10 E arrot MARYLAND b. CITY OR TOWN (if outside corporate limits, c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL end give neerest town) write RURAL and give nearest town) NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street eddress) d. STREET ADDRESS a. IS RESIDENCE hours ON A FARM? YES NO complete NAME OF Middle 4. DATE Month Dey Year DECEASED OF (Type or print) DEATH 19 5. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 9. AGE (In years | IF UNDER 1 YEAR IF UNDER 24 HRS. last birthday) Months Hours DIVORCED physician 10a. USUAL OCCUPATION (Give kind of work 10b. KIND OF BUSINESS OR INDUSTRY 12. CITIZEN OF WHAT COUNTRY State, or foreign country) done during most of working life, even if retired) 13. FATHER'S NAME 14. MOTHER'S MA attending p death 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address (Yes, no, or unkown) | (Ifyes give war or dates of service) 18. CAUSE OF DEATH [Enter only one cause per line for (e), (b), end (c).] INTERVAL BETWEEN ONSET, AND DEATH PART I. DEATH WAS CAUSED BY: 20mm IMMEDIATE CAUSE (e) DUE TO Conditions, if eny, which gave rise to immediate cause DUE TO (a), steting the underlying cause lest. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(e): 19. WAS AUTOPSY PERFORMED? NO CERTIFICA 2De. ACCIDENT WAS UNDERLYING [7] 2Db. DESCRIBE HOW INJURY OCCURED. (Enter neture of injury in Pert I or Pert II of item 18.) OR CONTRIBUTING [] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) MEDICAL 20c. TIME OF INJURY Month, Dey, Year 2Dd. INJURY OCCURRED 20e. PLACE OF INJURY (Home, ferm, 20f. (City or town) (County) (Stete) factory, street, office bldg., etc.) While Not While Hour e.m. at work et work 19 p.m 21. I certify that ((1)) (this hespital) attended the deceased from 19.66 saw the deceased alive on RE DATE 22e. SIGNATURE ATTENDING SIGNED MED DIRECTOR PHYS. PHYS. M.D. 22c. PHYSICIAN'S 22d. ADDRESS 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) (State) 23a. BURIAL, CREMATION, | 23b. DATE THEREOF 0.5 25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE VR A15 (4) FUNERAL DIRECTORS SIG ADDRESS 15M 7/61

F-6.350H Bet Timber Feet marchet Therendon state with no many Long View Reamy Jone Sic mystel Parker 2 28 40 - Elm St 1631/48/19 Factory Works Clark + Outer Bally Lo. 11 11 115 + Large Robinson neckeles Stranson. new plan Truck . Herber mit Maurice Perterfield M.D. Main Street; Hangstead, Mory land

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH and 2 death. hours after death PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. COUNTY b. COUNTY I in by the fa s. Pages 1 hours after Carroll Carroll Maryland MARYLAND CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) C. LENGTH CF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL end give nearest town) Finksburg 40 yrs Finksburg bon papers. within 72 ho filled d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) e. IS RESIDENCE ON A FARM? d. STREET ADDRESS YES X NO within letely carbon 3. NAME OF First Middle Last DATE Month Day DECEASED JOHN EDWARD PEELING July 23 1966 compl (Type or print) DEATH executed 5. SEX 6. COLOR OR RACE emove 7. MARRIED NEVER MARRIED 8. DATE OF BIRTH AGE (In years | IFUNDER 1 YEAR | IFUNDER 24 HRS. | last birthday) | Months | Days | Hours | Min. male white and Nov. 18,1896 WIDOWED [DIVORCED [10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) INDUSTRY 11. BIRTHPLACE (County & State, or foreign country) physician or please 12. CITIZEN OF WHAT be COUNTRY? metal worker in airplane factory Carroll Co., Maryland U.S.A. death certificate 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME attending parmit. Then Estella V. Barnes James Albert Peeling transit permit. 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address (Yes, no, or unkown) (If yes give war or dates of service) 212-03-4007 yes Mrs. Martha C. Peeling - same the 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] been signed by the the burial-transit or to burial, cremati INTERVAL BETWEEN law requires that the ONSET AND DEATH PART I. DEATH WAS CAUSED BY: Carcinomatosis VI IMMEDIATE CAUSE (a) DUE TO Carcinoma of bladder & colon 3 yrs. Conditions, if any, which gave rise to immediate DUE TO cause (a), stating the as th underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY certificate PERFORMED? the hospital or YES NO X PHYSICIAN: 20a, ACCIDENT WAS UNDERLYING DESCRIBE HOW INJURY OCCURRED, (Enter nature of injury in Part I or Pert II of Item 18.) detached fr OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) While Not While none at work at work 7-23-66, 19 0 7-2-65 21. I certify that (I) (this hospital) attended the deceased from olrector: age 3 should lied with the and that death occurred at 5:10 M. from the causes and on the date stated above. 7-22-66 saw the deceased alive on. 22a. SIGNATURE 22b. DATE SIGNED Page 4 may be 1 director, page should be filed v ATTENDING PHYS. MED. STAFF PHYS. 7-25-66 22d. ADDRESS 22c. PHYSICIAN'S NAME (Type) D. D. Caples, M. D. Hanover Rd., Reisterstown, Md. 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) BURIAL, CREMATION, (State) REMOVAL (Specify) Baltimore, Maryland 27.1966 Greenmount Cemetery 25a. REC'D BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE **FUNERAL DIRECTOR** Marley VR AI5 (4)

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	Rural Tane			D 7	m		1 1
-		y town	hospitel, give street address)	Rural	Taneytown	0	. IS RESIDEN
			nespitor, give sites dealess,	or other Abbae.			ON A FARM
13	NAME OF DECEASED	First	Middle	Last	4. DATE OF	Month Dey	Year
l	(Type or print)	Martin Luth	er Hess Reave	r	DEATH Jul	v 25	19 66
1	S. SEX			DATE OF BIRTH	9. AGE (In	yeers IF UNDER 1 YEAR	IF UNDER 24 HR
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	done during most of worki	ing life, even if retired)					
1	Farmer 3. FATHER'S NAME		wn farm	Maryland		U.S.	A
				14. WOLLEK, 2 WAIDI	EIA IAWE		
	Frankl	in Reaver		Ida Hes			
1	5. WAS DECEASED EVER Yes, no, or unknown) i (Ifye	IN U.S. ARMED FORCES?		NFORMANT		dress	
	No		215-34-2804 M	rs. Lina Re	eaver, R #1,	Littlestown	. Pa.
		ATH [Enter only one couse p	per line for (e), (b), end (c).]			IN	ERVAL BETWEEN
ı	PART I. DEATH	WAS CAUSED BY:	· oronary	Occh	ision	OF STATE OF	SET AND DEATH
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		DUE TO	Toxionslove	tie lla	IT Nises	12	Turn
	Conditions, if any, gave risa to immediate			Audi	and there		7
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	cause last.) (c) (c)	meralyed (unea	scurosi	23	in yes
140	PART II. OTHER S	IGNIFICANT CONDITIONS	CONTRIBUTING TO SEATH BUT NO	T RELATED TO THE TER	MINAL DISEASE CONDITION	GIVEN IN PART 1(a)	19. YAS AUTOP
TA A	Wreni	a ; Tuln	ronary En	nshysem	a lucy	maz"	YES NO
CERTICICA TION	20e. ACCIDENT WAS	UNDERLYING 20b.	DESCRIBE HOW INTURY OCCURRED	Entar nature of injury	y in Pert I or Pert II of item 1	3.)	
Cra	OR CONTRIBUTING (IF EITHER, NOTIFY M	CAUSE OF DEATH			1000		
44.4	20c. TIME OF INJURY	Month, Dey, Yaer 20	Od. INJURY OCCURRED 20e. PLA	CE OF INJURY (Home, f	farm, 20f. (City or fown)	(County)	(State)
TA CHOSA	Hour a.m.	W	/hile Not While fector	ory, street, office bldg.,			
4.4		17	work at work	N A 1			
	21. I certify tha	t (I) (this hospital) at	tended the deceased from.				
	saw the deceased	alive on July	19.66, and that	death occurred at.	Girom the cau	les and on the dat	e stated abov
	22e. SIGNATURE	00 20					22b. DAT
	8 m	ble Th	ougson "	D. PHYS.	MED. STAFF	0 7/	26/66
	22c. PHYSICIAN'S			22d. ADDRESS			- 0100
	NAME (Type)	E. Ambler Thom	mpson, M.D.	49 Frede	rick Street,	Tanevtown.	Md.
-		N, 23b. DATE THEREOF	23c. NAME OF CEMETERY		23d. LOCATION (Cit		(State)
ľ	REMOVAL (Specify)						
	Burial	July 28, 19	66 Lutheran Ce	metery	Harney	Marylan	d
				1		DECLERA A DIE CO	PLIPP
	PUNERAL DIRECTOR'S	SIGNATURE	ADDRESS ss & Son, Taneyt		REC'D BY REGISTRAR 256	REGISTRAR'S SIGNA	TURE

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MARYLAND STATE DEPARTMENT OF HEALTH VISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH funeral and 2 death. after death PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. CDUNTY b. COUNTY Carroll Nd. Carroll MARYLAND carbon papers. Pages. b. CITY OR TOWN (if outside corporate limits, c. LENGTH OF STAY IN 1b c. CITY DR TOWN (If outside corporate limits, write RURAL and give nearest town) hours write RURAL and give nearest town) Finksburg Finksburg = d. NAME OF HOSPITAL DR INSTITUTION (if not in hospital, give street address) e. IS RESIDENCE filled d. STREET ADDRESS ON A FARM? 4 Cedarhurst Road 4 Cedarhurst Road NO YES within completely NAME OF First Middle DATE Month Day Year Lest and come remove carbu-DECEASED John Rhodes DEATH (Type or print) July 19 66 6. CDLOR OR RACE | 7. MARRIED TO NEVER MARRIED AGE (In years | IF UNDER 1 YEAR | IF UNDER 24 HRS 5. SEX 8. DATE DF BIRTH last birthday) Months I Davs in any Male White WIDDWED [May 30, 1903 63 DIVORCED 1Da. USUAL OCCUPATION (Give kind of work done | 10b. KIND DF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN DF WHAT sician lease r and in during most of working life, even if retired) COUNTRY? INDUSTRY Barber New York attending physic smit. Then plea n, or removal, an USA death certificate 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME Charles S. Rhodes Eliza Miller 15. WAS DECEASED EVER IN U.S. ARMED FDRCES? 16. SDCIAL SECURITY NO. 17. INFORMANT Address (Yes, no, or unkown) (If yes give war or dates of service) 218-18-1318 transit pern cremation, Mrs. Grace A. Rhodes Finksburg, Md. 18. CAUSE DF DEATH [Enter only one cause per line for (a), (b), and (c),] INTERVAL BETWEEN that the ONSET AND DEATH ned by Il-transi PART I. DEATH WAS CAUSED BY: Cerebral Hemorrhage the hospital or attending physician. hrs IMMEDIATE CAUSE (a) signed burial-t burial, DUE TO Hypertensive C.V. Disease Conditions, If any, which vears been the br gave rise to immediate DUE TO cause (a), stating the underlying cause last. has as CERTIFICATION PART II. DTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) WAS AUTDPSY 19. for use Health certificate label for use of Health PERFORMED? NO 20a. ACCIDENT WAS UNDERLYING TO DR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) PHYSICIAN: 2Db. DESCRIBE HOW INJURY OCCURRED, (Enter nature of injury in Pert I or Part II of Item 18.) MEDICAL 2Dc. TIME DF INJURY Month, Day, Year 20d. INJURY OCCURRED | 2De. PLACE DF INJURY (Home, farm, (State) 20f. (City or town) (County) factory, street, office bldg., etc.) Hour a.m. While Not While at work at work 1966 to July 4 19.66. that (I) (we) last P July 21. I certify that (I) (this hospital) attended the deceased from_ 3 should with the 19 66, and that death occurred at IIP M, from the causes and on the date stated above. saw the deceased alive on Tilly 22a. SIGNATURE 22b. DATE SIGNED DIR. MED.
DIRECTOR ge martino PHYS. 4 may pa HOSPITAL FUNERAL 22c. PHYSICIAN'S 22d. ADDRESS director, p NAME (Type) Martin E. Strobel. Main St. Reisterstown. Md. BURIAL, CREMATION, 23b. DATE THEREOF REMOVAL (Specify) 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) (State) Finksburg, Md. 166 Burial Evergreen Memorial REC'D BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE 24. FUNERAL DIRECTOR J. F. Eline & Sons Reisterstown, Md. VR A15 (4) DATE 20M 1/65

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Clail agoni . E8- E021 .00 Toller Tenr-York THE SILE OF SELECT the life in the life of the life of the deal of the life of the li Bushall SAT 6 Energy Markerlal Simple of Chilabour, 10.

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 09759 CERTIFICATE OF DEATH The law requires that the death certificate be executed within 24 haurs after death. and campletely filled in by the funeral remave carbon papers. Pages 1 and 3 n any event, within 72 hours after death 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) 1. PLACE OF DEATH b. COUNTY Washington Carroll o. STATE o. COUNTY Maryland MARYLAND c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) b. CITY OR TOWN (If outside corporate limits. c. LENGTH OF STAY IN 1b write RURAL and give negrest town) 21722 Clear Spring 5m 124 (Rural) Sykesville d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street oddress) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? Route #1 unknown Springfield State Hospital NO 3. NAME OF DECEASED (Type or print) Middle 4. DATE Month Doy Year Lost INSON 19 66 DEATH AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS. DATE OF BIRTH S. SEX 6. COLOR OR RACE NEVER MARRIED 7. MARRIED 78 lost birthdoy) Months Hours 7-2-87 Dovs white Male K WIDOWED DIVORCED 11. BIRTHPLACE (County & Stote, or foreign country) 12. CITIZEN OF WHAT 10b. KIND OF BUSINESS OR 10o. USUAL OCCUPATION (Give kind of work done USA INDUSTRY 66 COUNTRY? during most of working life even if retired) physician (Pa. 14 MOTHER'S MAIDEN NAME 13. FATHER'S NAME Nancy Carbaugh John Robinson burial, crematian, ar remov attending p 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give wor or dotes of service) 16. SOCIAL SECURITY NO. INFORMANT Address signed by the attendi burial-transit permit. 215-26-0812 Hospital Records 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), ond (c).

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (o)

Bronchopne INTERVAL BETWEEN 3 ONSET AND DEATH Bronchopneumonia DUE TO Arteriosclerotic cardiovascular disease vears Conditions, if ony, which gove rise to immediate couse (a) DUE TO stoting the underlying couse Page 4 may be retained by the haspital ar attending this certificate has been directar, page 3 shauld be detached far use as the shauld be filed with the State Dept. af Health priar ta PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(2) Chronic brain syndrome associated with cerebral arteriosclerosis 19. WAS AUTOPSY PERFORMED? NO 3 YES 205. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.) 20o. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) (City or town) (County) (Stote) 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, 20c. TIME OF INJURY Month, Doy, Yeor foctory street, office bldg., etc.) Hour o.m. ot work O FUNERAL DIRECTOR: After 19 66 to 7-7-1-25 21. I certify that (this hospital) ottended the deceased from. 1966, and that death accurred at 7:30aM, fram causes and on the date stoted above. saw the deceased alive an 22b. DATE SIGNED 7-7-66 22o. SIGNATURE 40 DIRECTOR PHYS. M.D. 22d. ADDRESS Springfield State Hospital Wise III, M.D. S. P. 22c. PHYSICIAN'S NAME (Type) 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (Stote) 230. BURIAL, CREMATION, 23b. DATE THEREOF (County) St. PAUL'S NEAR LEARSPRING, WASH 9-66 EMETERY 25b. REGISTRAR'S SIGNATURE BY REGISTRAR 2So. RECID 24. FUNERAL DIRECTOR 1986 LBERT LILEAR WILLIAMSPORTA DATE

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DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1. MARYLAND CERTIFICATE OF DEATH 09760 director, led with PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. COUNTY filed ARROL b. COUNTY MARYLAND death. c. LENGTH OF STAY IN 16 b. CITY OR TOWN (If outside corporale limits, write c. CITY OR TOWN outside corporate limits, write RURAL and give nearest town) RURAL and give nearest town) Kesville P d. NAME OF HOSPITAL (# not in hospital, give street address) d. STREET ADDRESS OR INSTITUTION 00 2 NAME OF First Middle 4. DATE Month DECEASED DEATH (Type or print) de 9. AGE (In years 6. COLOR OR RACE 7. MARRIED A NEVER MARRIED B. DATE OF BIRTH lost birthdoy) WIDOWED [DIVORCED [USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) during most of working life, even if retired) pd pup 14. MOTHER'S MAIDEN NAME 13. FATHER'S NAME 17. INFORMANT 15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO. 18. CAUSE OF DEATH [Enter only one couse per line for (o), (b), and (c)." PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (o) DUE TO Conditions, if ony, which gned gove rise to immediate DUE TO couse (o), stoting the underlying couse lost Man PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19. WAS AUTOPSY 20a. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF DEATH 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port I or Port II of ilem 18.) (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY 20e. PLACE OF INJURY (Home, form, 20f. (City or town) Month, Doy, Year 20d. INJURY OCCURRED foctory, street, office bldg., etc.) Hour o. m. While Not while ot work ot work p. m 7-22 21. I certify that (1) (this hospital) attended the deceased from._____ 1966. saw the deceased alive on 22o. SIGNATURE ATTENDING M.D. PHYS. DIRECTOR | PHYS. OR 22c. PHYSICIAN'S 22d. ADDRESS o P NAME (Type) page 3 the State 23g. BURIAL CREMATION. 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY REMQVAL₃(Specify) 0 FUNERAL DIRECTOR'S SIGNATURE 25a. REC'D BY REGISTRAR 1SM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

e. IS RESIDENCE ON A FARM? YES NO Day Yeor 1966 IF UNDER 1 YEAR IF UNDER 24 HRS Months Days 12. CITIZEN OF WHAT COUNTRY? Address INTERVAL BETWEEN ONSET AND DEATH

> PERFORMED? YES NO DE

> > (Stote)

SIGNED

(County)

1966, that (1) (we) last and that death accurred at 9.A.M., from the causes and an the date stated above. 22b DATE

23d. LOCATION (City, town, or county) (Stote)

REGISTRAR'S SIGNA

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH

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20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED While at work 19	ATI	Chronic brain syndrome associated wit	h sanile hrain disease and her PERFORMED?
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21. I certify that (I) (this hospital) attended the deceased from 7-21-65, 19, to 7-21-66, 19, that (I) (we) last saw the deceased alive on 7-21-66 19, and that death occurred at 7 P. M, from the causes and on the date stated above. 22a. SICNATURE Wm. R. Igbal ATTENDING MED. DIRECTOR PHYS. 22b. DATE SIGNEO	정	factor	CE OF INJURY (Home, farm, 20f. (City or town) (County) (State)
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22a. SICNATURE Wm. R. Icbal M.D. PHYS. DIRECTOR PHYS.			t death occurred at 7 P. M. from the causes and on the date stated above.
22c. PHYSICIAN'S NAME (Type) 23a. BURIAL, CREMATION, 23b. DATE THEREOF REMOVAL (Specify) Physician's Physician's Phys. Director Phys. Director Phys. 22d. Address 23d. Location (City, town or county) (State) Wesley Chapel -Rock Hall, Md. 24. FONERAL DIRECTOR ADDRESS, ADDRESS, REGISTRAR 25b. REGISTRAR'S SIGNATURE Loring Byers-8728 Liberty Rd. Randallstewn, Md. 25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE	100		22b. DATE SIGNEO
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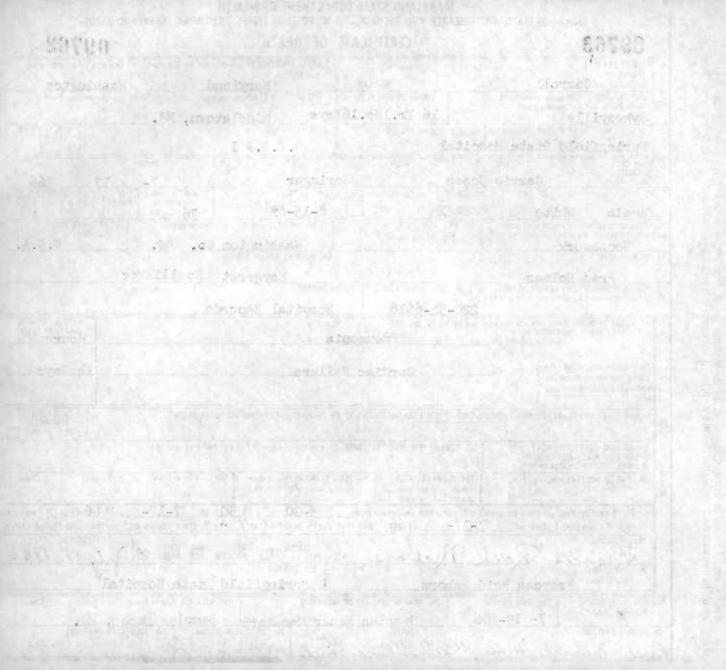
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MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH 09764 requires that the death certificate be executed within 24 haurs after death 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) campletely filled in by the funeral ave carban papers. Pages Land PLACE OF DEATH O_COUNTY Maryland Carroll Carroll MARYLAND b. CITY OR TOWN (If autside corporate limits, write RURAL and give nearest town) c. CITY OR TOWN (If autside carporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 1b Hampstead R.D.1 Westminster d. STREET ADDRESS d. NAME OF HOSPITAL OR INSTITUTION (If nat in haspital, give street address) IS RESIDENCE within 72 ON A FARM? Carroll Co. Gen. Hospital Gill Ave. NO EX 3. NAME OF Middle remave carban Last 4. DATE Manth Day DECEASED 2510 NORMAN P. STEPHAN (Type or print) DEATH SEX 6. COLOR OR RACE 8. DATE OF BIRTH IF UNDER 1 YEAR IF UNDER 24 HRS. 9. AGE (In years 7. MARRIED NEVER MARRIED las birthday) Months Hours 9/10/15 White Male WIDOWED DIVORCED 10a. USUAL OCCUPATION (Give kind of wark dane 10b. KIND OF BUSINESS OR 11, BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT INDUSTRY COUNTRY? during mast of working life even if retired) Maryland 14. MOTHER'S MAIDEN NAME 13. FATHER'S NAME Walter Stephan Mary Walsh 1S. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, na, ar unknown) (If yes give wor or dotes af service) 16. SOCIAL SECURITY NO. 17. INFORMANT Address Mrs. Margaret Stephan, Hampstead. Md -711-27.81 no 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).) INTERVAL BETWEEN ransit ONSET AND DEATH PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO burial-t Conditions, if any, which gave rise to immediate cause (o). DUF TO stating the underlying cause O FUNERAL DIRECTOR: After this certificate has been the 19. WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) far use NO the hospital or 20a. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I or Part II of item 1B.) OR CONTRIBUTING CAUSE OF DEATH detached (IF EITHER, NOTIFY MEDICAL EXAMINER) (City or town) 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, (County) (Stote) Haur a.m. foctory, street, affice bldg., etc.) Nat While ot work ot work 21. I certify that (I) (this hospital) attended the deceased fram 25 1966 ta 25, 1966, that (1) (we) last 25, 19 64, and that death occurred at 7 35 M, from causes and an the date stoted above. saw the deceased alive on 22b. DATE SIGNED 22a, SIGNATURE DIRECTOR 22d. ADDRESS 22c. PHYSICIAN'S NAME (Type) director, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) 23o. BURIAL, CREMATION, (County) (State) Burial (Specify) 7/28/66 Immanuel Cemeterv Manchester Md. 2Sb. REGISTRAR'S SIGNATURE 2So. REC'D BY REGISTRAR 24. FUNERAL DIRECTOR VR A15 (4) 1966 Tipton-Eline Hampstead, Md. 20 M 1/66 DATE

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MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH PHYSICIAN: The law requires that the death certificate be executed within 24 haurs after death PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. COUNTY arrae b. COUNTY b. CITY OR TOWN (If outside corporate limits. c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) write RURAL and give nearest town Manchester nonclus e. IS RESIDENCE ON A FARM? d. STREET ADDRESS d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street oddress) 207 S Main Street 209 S. Main St. YES NO X 3. NAME OF Middle DATE DECEASED (Type or print) DEATH S. SEX 6. COLOR OR RACE DATE OF BIRTH AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS. 7. MARRIED **NEVER MARRIED** birthdoy) Dovs Hours 6/24/95 White Male WIDOWED DIVORCED 10o. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT during most of working life even if refired)
County Rds. Employee asp INDUSTRY Maryland 14. MOTHER'S MAIDEN NAME 13. FATHER'S NAME Ida Yingling Franklin Stephan 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO 17. INFORMANT Address (Yes, no, or unknown) (If yes give wor or dotes of service) 219-07-1941 Mrs. Melvie Stephan Manchester. Md. no INTERVAL BETWEEN 1B. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).) burial-transit ONSET AND DEATH PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) DUE TO Conditions, if ony, which gove rise to immediate couse (a), DUE TO stoting the underlying couse TO FUNERAL DIRECTOR: After this certificate has been the 19. WAS AUTOPSY PERFORMED? OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) NO 20o. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port 1 or Port 11 of item 18.) (IF EITHER, NOTIFY MEDICAL EXAMINER) 20e. PLACE OF INJURY (Home, form, (City or town) (County) (Stote) 20d. INJURY OCCURRED 20c. TIME OF INJURY Month, Day, Year foctory, street, office bldg., etc.) Not While 21. I certify that (I) (this hospital) attended the deceased fram 190, 167, 19, 19, that (I) (we) lost saw the deceased glive an 1966, and that death accurred at 50 M, fram causes and on the date stated above. that (I) (we) lost saw the deceased alive an_ 22a SIGNATURE 22b. DATE SIGNED ATTENDING DIRECTOR M.D. PHYS directar, page should be filed 22d. ADDRESS Hampstead, Md. PHYSICIAN'S M.C. Porterfield NAME (Type) 23o. BURIAL, CREMATION 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (County) (Stote) BHOYALISECTY) 7/31/66 Leister's Cemetery Westminster Md. 2Sb. REGISTRAR'S SIGNATURE 24. FUNERAL DIRECTOR 25o, REC'D BY REGISTRAR VR A15 (4) 20 M 1/66 Tipton-Eline Hampstead. Md. DATE

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funeral 1 and 2 or death.	09767 CERTIFICATE OF DEATH	09766
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2		ON A FARM?
=	3. NAME OF First Middle Last LA DATE Month	Day Year
Т	DECEASED (Type or print) Sarah Levy Twigg DEATH July	1 1966
1	5. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 8. DATE OF BIRTH 9. ACE (In years IF UNDER	
+	- ast birtinday) (Months	Days Hours Min.
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-	Harris Levy Bessie Simon 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address	
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-	No None Springfield Hospital, Sykesvill	e. Md.
	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]	INTERVAL BETWEEN ONSET AND DEATH
	PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac failure	
	JEIN DUE TO CONSTRUCT NO. 1	1 3 3 Th 15
1	Conditions, If any, which gave rise to immediate (b) Cerebral Vascular Accident.	
T	cause (a), stating the DUE TO	Die Control
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	Hour a.m. While Not While at work at work	
1	21. I certify that (tx(this hospital) attended the deceased from February 18 1966, to July 3, 196	56, that stikiwe) last
1	saw the deceased alive on July 1 19.66, and that death occurred at 3:30 Milfrom the causes and on the	ne date stated above.
	226. \$ICNATURE 22b. D.	ATE SICNED
	APC MED. STAFF DIRECTOR DIRECTOR PHYS. D	
	22c. PHYSICIAN'S Naci Buyukunsal, M.D. 22d. ADDRESS Springfield State F	Hospital
	Sykeaville, Marvlar	10
	23a. BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or countries)	8.4.0
	Burial July 3. 1966 East View Cemetery Cumberland, Al-	legany, Md.
1	24. FUNERAL DIRECTOR 259. REC'D BY RECISTRAR 25b. REGISTRAR	
3	John Jaler Balton ave DATE 111 5 1966 Ichan	res judge
4-		0

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DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH funeral 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where decessed lived, If institution, Residence before admission) a. COUNTY Carroll Maryland b. COUNTY Frederick by the and 2 death. MARYLAND c. CITY OR TOWN (If outside corporete limits, write RURAL end give neerest town) b. CITY OR TOWN (if outside corporate limits. c. LENGTH OF STAY IN 16 Middleburg Lantz Vr. hours aft d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street eddress) d. STREET ADDRESS . IS RESIDENCE ON A FARM? Brookfield Manor Nursing Home YES NO K 3. NAME OF Last 4. DATE Month Dev complete Yeer DECEASED (Type or print) MARY WAYNANT DEATH July 66 19 within 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 9. AGE (In years | IF UNDER 1 YEAR IF UNDER 24 HRS. 8. DATE OF BIRTH (asbirthday) pue Months Devs Female WIDOWED [DIVORCED physician 10a. USUAL OCCUPATION (Give kind of work 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT COUNTRY? done during most of working life, even if retired) Own Home Pennsylvania USA Housewiie 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME please attending Marion J. Bender Amaricus E. Waynant 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 1 17. INFORMANT Address (Yes, no, or unkown) [(Ifyesgive werordetes of service Sabillasville, Md. Vaughn Waynant None attending physician. as been signed by the 18. CAUSE OF DEATH |Enter only one cause per line for (e), (b), and (c).) INTERVAL BETWEEN ONSET, AND DEATH PART I, DEATH WAS CAUSED BY: 2 days IMMEDIATE CAUSE (e) Experil atheroschessis. DUE TO Conditions, if any, which geve rise to immediate cause DUE TO (a), stelling the underlying couse last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) | 19. WAS AUTOPSY PERFORMED? NO X 20b. DESCRIBE HOW INJURY OCCURED, (Enter nature of injury in Part I or Pert II of item 18.) 20e. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH MEDICAL 20d. INJURY OCCURRED 20e, PLACE OF INJURY (Home, ferm, 20f. (City or town) (County) (Stete) 20c. TIME OF INJURY Month, Dey, Yeer fectory, street, office bldg., etc. While Not While Hour a.m. et work at work, 19....., that (I) (we) last 21. I certify that (I) (this hospital) affended the deceased from..... IRECT 19......, and that death occurred at M. from the causes and on the date stated above. saw the deceased alive on. 22b. DATE 22e. SIGNED ATTENDING STAFF N DIRECTOR PHYS. 22d. ADDRESS 22c. PHYSICIAN'S FUNER NAME (Type) Union Bridge, Maryland Caricofe 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) 23a. BURIAL, CREMATION, | 23b. DATE THEREOF (State) REMOVAL (Specify)
Burial Blue Ridge Cemetery Fred. Co. Md. 8-3-66 Thurmont 2Se. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE 24 FUNERAL DIRECTOR'S SIGNATURE Raymond E. AUNG ager VR A15 (4) Thurmont, Md. DATE 15M 7-62

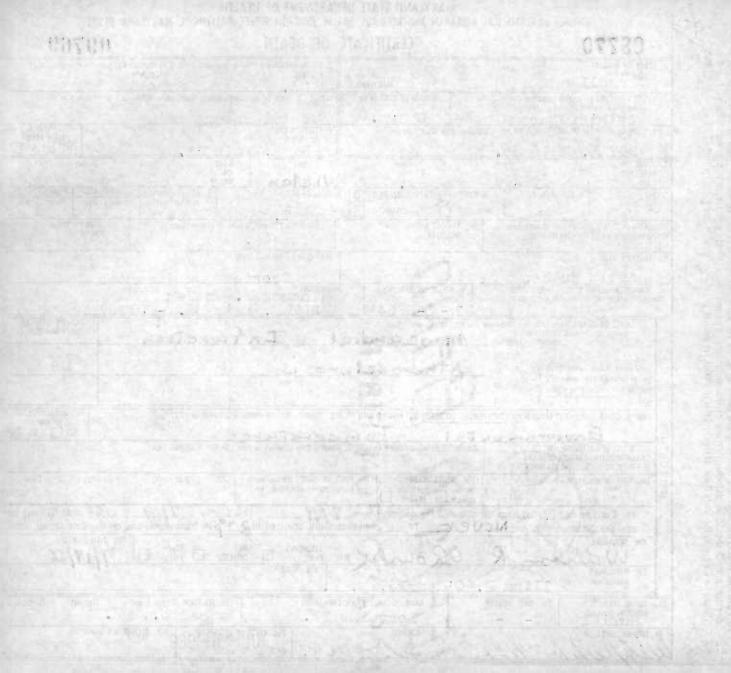
MARYLAND STATE DEPARTMENT OF HEALTH

Z - I THE Phone of the second state of the second The second secon TOTAL COLUMN COL Manual Indianal Annaver of the second serial The course of th higher their period of the second state of the Unity and the mound distributed . R. C . DE . OD . BETT BROWERE TO STATE CONTROL VISITED TO THE CONTROL OF THE CONTROL O HIRTORIAN SAME TO STATE OF THE PROPERTY OF THE The state of the s

STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH funeral 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. COUNTY b. COUNTY arro MARYLAND 幸 7年 b. CITY OR TOWN (if outside corporate limits, c. LENGTH OF STAY IN 16 outside corporete limits, write RURAL end give nearest town c. CITY OR TOWN (If write RURAL and give nearest town) Pages d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address a. IS RESIDENCE d. STREET ADDRESS ON A FARM? YES NO complete 3. NAME OF 4. DATE Middle Day DECEASED OF (Type or print) DEATH 029 196 and cor 6. COLOR OR RACE 7. MARRIED 5. SEX AGE (In years IF UNDER 1 YEAR **IF UNDER 24 HRS.** 8. DATE OF BIRTH NEVER MARRIED lest birthday) The law requires that the death certificate be Months Deys Hours WIDOWED physician 10a. USUAL OCCUPATION (Give kind of work 1Db. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (County & State, or 12. CITIZEN OF WHAT COUNTRY? foreign country) dona during most of working life, even if retired) 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME Then please Sarah 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT (Yas, no, or unkown) | (Ifyesgive war or dates of service) 18. CAUSE OF DEATH lEnter only one cause per-line for (a), (b). ONSET AND DEATH been signed by PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) DUE TO Conditions, if any, which (b) gave rise lo immadiata causa DUE TO (a), stating the underlying causa lest. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY PART IL CERTIFICATION PERFORMED? NO 20b. DESCRIBE HOW INJURY OCCURED. (Enter neture of injury in Part I or Pert II of item 18. 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH for MEDICAL 20e. PLACE OF INJURY (Home, ferm, (Steta) 20d. INJURY OCCURRED 2Df. (City or town) (County) 20c. TIME OF INJURY Month, Day, Yeer lactory, street, office bldg., etc.) While Not While Hour a.m at work at work D.M. 19 21. | certify that (1) (this hospital) attended the deceased from, and that death occurred at !! P.M. from the causes and on the date stated above. saw the deceased alive on 22e. SIGNATURE 22b. DATE ATTENDING STAFF SIGNED! DIRECTOR PHYS. PHYS. M.D. 22d. ADDRESS 22c. PHYSICIAN'S NAME (Type) 23d. LOCATION (City, town or county) 23c. NAME OF CEMETERY OR CREMATORY 23a. BURIAL, CREMATION, | 23b. DATE THEREOF (Stata) REMOVAL (Specify) N.Y. MacPelah Cemetery Brooklyn 25e. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE 24 FUNERAL DIRECTOR'S SIGNATURE ADDRESS VR A15 (4) Tipton-Eline Hampstead. Md. 15M 7-62 DATE

STREET. New York King S New York City The state of highe Time 210 at 24 Sheet Little Jay 29 66 Emle white : x = 20 1871 94 House wife Holyake Mass Wash Someel Keller Sarah Welff 298-12 1845 Institution Records Monteste Al Maine Portefeel no Man Stat Hangstond Maryland marriage and control defendent and the second second

at	09770 CERTIFICA	TE OF DEATH	09769
A	1. PLACE OF DEATH C. COUNTY MARYLAND	2. USUAL RESIDENCE (When	re deceased lived, if institution: Residence before admission) b. COUNTY Carroll
	b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Vestminister c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside Westminis	e carporote limits, write RURAL and give neorest town)
	d. NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address)	d. STREET ADDRESS	e. IS RESIDENCE ON A FARM?
	297 E. Main St. 3. NAME OF First Middle		DATE Manth Day Year
	DECEASED (Type or print) Gladys 6. COLOR OR RACE 7. MARRIED NEVER MARRIED	B. DATE OF BIRTH	OF DEATH JIJ 77 0 19 66 9. AGE (In yeors FUNDER YEAR IF UNDER 24 HRS. Is birthday) Months Days Hours Min.
	WIDOWED DIVORCED	Tune 7 190	
	13. FATHER'S NAME	Maryland 14. MOTHER'S MAIDEN NAM	
	Martin Hughes 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dotes af service) 215-03-8604	Bessie 7. INFORMANT Thomas M. 297 E. Ma	Whelan Address
	1B. CAUSE OF DEATH (Enter only one cause per line for (o), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o)		Parction INTERVAL BETWEEN ONSET AND DEATH
	Conditions, if any, which gave rise to immediate couse (a), stoting the underlying couse last. DUE TO (b) Atheroscl (c)	eros is	?
2	PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED	noerature	YES NO
	EARLOF IN COLOR TO CO		
	20c. TIME OF INJURY Month, Doy, Year Haur o.m. p.m. 19 20d. INJURY OCCURRED While of work of work	PLACE OF INJURY (Home, form, factory, street, affice bldg., etc.)	20f. (City or tawn) (County) (State)
		that death accurred at 2	M, fram causes and an the date stated abov
1	220. SIGNATURE William R ORousse 22c. PHYSICIAN'S	M.D. ATTENDING ME PHYS. DIR 22d. ADDRESS	D. STAFF 22b. DATE SIGNED PHYS. 7/19/46
	NAME (Type) William R. O'Rourke, M. 23a. BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY	OR CREMATORY	23d. LOCATION (City or Town) (County) (State)



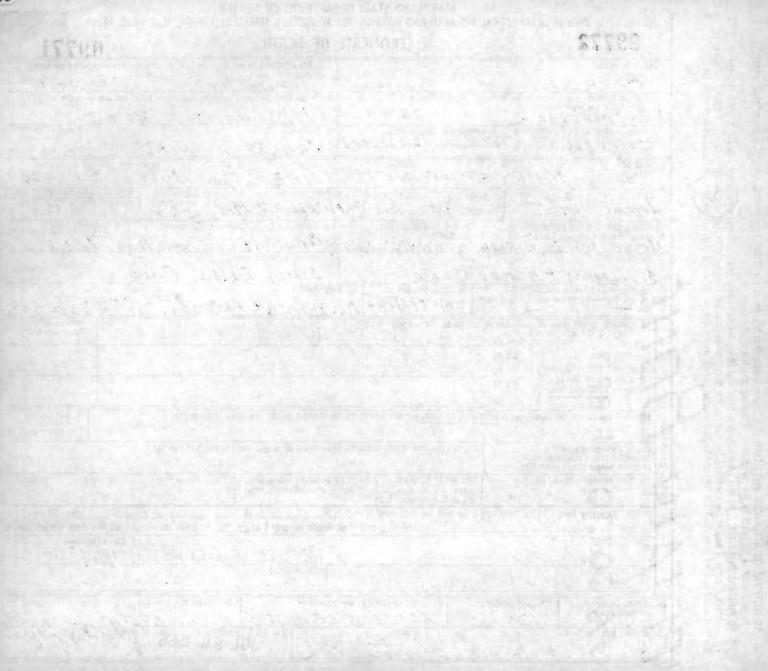
MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH death requires that the death certificate be executed within 24 haurs after death and 2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission) filled in by the funeral papers. Pages 1 and PLACE OF DEATH o. COUNTY b. COUNTY Carroll Maryland Carroll emave carban papers. Pages 1 any event, within 72 haurs after MARYLAND c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) b. CITY OR TOWN (If autside carparate limits, Rural--Sykesville Woodbine 11m. 22d. e. IS RESIDENCE ON A FARM? d. STREET ADDRESS d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street oddress) Springfield State Hospital Route #1 □ NO □ and campletely fi Middle 3. NAME OF Lost 4. DATE Month First Year DECEASED 19 66 Maudie Belle White DEATH (Type or print IF UNDER 1 YEAR IF UNDER 24 HRS DATE OF BIRTH 9. AGE (In veors S. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED Months birthdov) Hours 3/17/87 white female 30 WIDOWED DIVORCED and 11. BIRTHPLACE (County & Stote, or foreign country) 12. CITIZEN OF WHAT 10o. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR the attending physician an insit permit. Then please remarked and in COUNTRY? during most of working life, even if retired) INDUSTRY USA Virginia 14. MOTHER'S MAIDEN NAME 13. FATHER'S NAME crematian, or remay Thomas Sargent Luella Rogers 17. INFORMANT 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give wor or dotes of service) 16. SOCIAL SECURITY NO. 216-10-1224 Springfield Hospital records, Sykesville INTERVAL BETWEEN 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).) signed by the burial-transit p ONSET AND DEATH PART I. DEATH WAS CAUSED BY Congestive heart failure IMMEDIATE CAUSE (o) DUE TO Conditions, if any, which gove rise to immediate cause (o), DUE TO stating the underlying couse attending as the has been last. WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) hronic brain syndrome with cerebral arteriosclerosis with psychotic reaction. use of Health NO Page 4 may be retained by the haspital ar O FUNERAL DIRECTOR: After this certificate director, page 3 should be detached far us 205. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.) 20o, ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER 20e. PLACE OF INJURY (Home, form, 20f. (City or town) (County) (Stote) 20d. INJURY OCCURRED 20c. TIME OF INJURY Month, Doy, Year Hour o.m. foctory, street, office bldg., etc.) Not While ot wark 21. I certify that (If (this haspital) attended the deceased from. 19 64 1956, that the (we) last 19 66, and that death occurred of 6:30 M, from causes and an the date stated obove saw the deceased alive on_ 22b. DATE SIGNED 220. SIGNATURE STAFF PHYS. **ATTENDING** X DIRECTOR M.D. page Springfield State Hospital 22d. ADDRESS 22c. PHYSICIAN'S Moises Sucholeiki, M.D. NAME (Type) Sykesville, Maryland directar, p 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (State) 23o. BURIAL CREMATION. 23b. DATE THEREOF REMOVAL (Specify) low 25o, REC'D BY REGISTRAR 25th REGISTRAR'S SIGNATURE FUNERAL DIRECTOR **ADDRESS** VR A15 (4) 20 M 1/66 1946

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Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 09772 CERTIFICATE OF DEATH death. requires that the death certificate be executed within 24 haurs after death y filled in by the funeral pn papers. Pages 1 and vithin 72 haurs after death . PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) O. COUNTY PARROLL o. STATE b. COUNTY MARYLAND ARROLL b. CITY OR TOWN (If autside corporate limits, c. LENGTH OF STAY IN 1h c. CITY OR TOWN (If autside corporate limits, write RURAL and give negrest town) write RURAL and give nearest tawn) 25 YRS. TMINSTE d. NAME OF HOSPITAL OR INSTITUTION (If nat in haspital, give street address) IS RESIDENCE d. STREET ADDRESS CO. GENERAL HOSPITAL CARROLL 60 YES NO P NAME OF DATE Day Year DECEASED (Type or print) JULY 1966 DEATH v event. 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS. lost birthday) Manths Days Hours Геп 11. BIRTHPLACE (County & Stote, or foreign country) 10%, USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 12. CITIZEN OF WHAT physician a during most of warking life, even if retired) INDUSTRY LFOUSE -WIFE

13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME the attending physical properties of the property of the prope ARR 16. SOCIAL SECURITY NO. 17. INFORMANT Address (Yes, na, ar unknown) (If yes give war ar dates af service) 505 E. MAINS ST. 219-01-1765 CAUSE OF DEATH (Enter only one cause per line for (g), (b), and (c).)
PART I. DEATH WAS CAUSED BY: INTERVAL BETWEEN burial-transit ONSET AND DEATH IMMEDIATE CAUSE (a) signed by 4201 DUE TO Conditions, if ony, which gove rise to immediate couse (a). DUE TO stating the underlying cause O FUNERAL DIRECTOR: After this certificate has been the 19. WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) NO YES Po 20a. ACCIDENT WAS UNDERLYING [20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I or Part II of item 18.) OR CONTRIBUTING CAUSE OF DEATH detached (IF EITHER, NOTIFY MEDICAL EXAMINER) (City or town) 20e. PLACE OF INJURY (Home, form, (County) (Stote) 20c. TIME OF INJURY Month, Doy, Year 20d. INJURY OCCURRED Hour a.m. factory, street, office bldg., etc.) Not While at work at wark 21. I certify that (1) (this haspital) attended the deceased fram 7/21/66 . 19 ____, that (I) (we) last 1966, and that death accurred at 1/25 M, fram causes and an the date stated above. saw the deceased alive an 220 SIGNATURE 22b. DATE SIGNED M.D. DIRECTOR 22d. ADDRESS 22c. PHYSICIAN'S Page 4 may NAME (Type) Ruchen directar, should 23a. BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (County) REMOVAL (Specify) LEISTERS **FUNERAL DIRECTOR**

MARYLAND STATE DEPARTMENT OF HEALTH



Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND FOR STATE MEDICAL EXAMINER'S CERTIFICATE OF DEATH HEALTH DEPT. PLACE DF DEATH a. COUNTY USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) b. COUNTY MARYLAND b. CITY DR TOWN (If outside corporate limits, c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) write RURAL and give nearest town). animorus the 5 d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) d. STREET ADDRESS e. IS RESIDENCE DN A FARM? ay 18 3 to Page State hours NO YES and and NAME OF First Middle 4. DATE Month Day Year DECEASED (Type or print) DEATH 19 2 with within 5. SEX 6. COLOR OR RACE IF UNDER 1 YEAR IF UNDER 24 HRS. DAT E OF BIRTH AGE (In years 7. MARRIED NEVER MARRIED lest birthdey) Months | rited within 24 hours after death. I in pencil in Item 18, GIVe Pages Examiner's Office alone with for Days Hours WIDOWED DIVORCED and 1Da. USUAL OCCUPATION (Give kind of work done) 10b. KIND DF BUSINESS OR 12. CITIZEN OF WHAT BIRTHPLACE (State or foreign country) during most of working life, even if retired) INDUSTRY COUNTRY? Laborer 45 a any 13. FATHER'S NAME MOTHER'S MAIDEN NAME E Take File pand 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. Address (Yes, no, or unkown) | (If yes give war or dates of service) permit. removal, ACEXAMINER: This certificate should be executed within the certificate, writing the word "pending" in pencil is should be forwarded to the Chief Medical Examiner's CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: burial-transit IMMEDIATE CAUSE (e) DUE TO Conditions, If eny, which (b) geve rise to immediate DUE TO cause (a), steting the underlying couse last, (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(e) WAS AUTDPSY CERTIFICATION PERFORMED? Sic YES NO DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) 20a. EXTERNAL CAUSE WAS PRIMARY OF CONTRIBUTING CAUSE OF DEATH. should lent, pri 3 shou agent, MEDICAL 20c. TIME OF INJURY Month, Day, Year 2Dd. INJURY DCCURRED 120e. PLACE OF INJURY (Home, farm, 20f. (City or town) (County) (State) factory, street, office bldg., etc.) Hour a.m. While Not While at work at work FUNERAL DIRECTOR: Page Health or its designated 21. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry and In my ppinion Accident Homicide Undetermined manner death resulted from: Natural causes CHIEF MEDICAL EXAMINER 4 for your Page 22. DATE SIGNED ASSISTANT MEDICAL EXAMINER SIGNATURA M.D. Chic DEPUTY MEDICAL EXAMINER please ex director. retained **EXAMINER'S** Address (Street, city, town, or county) NAME (Type) LDCATION (City, town or county) BURIAL, CREMATION, 23b. DATE THEREOF NAME OF CEMETERY OR CREMATORY (State) REMOVAL (Specify) 0 emoter **EUNERAL DIRECTOR** REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE **ADDRESS** 25a. VR ALSME 15

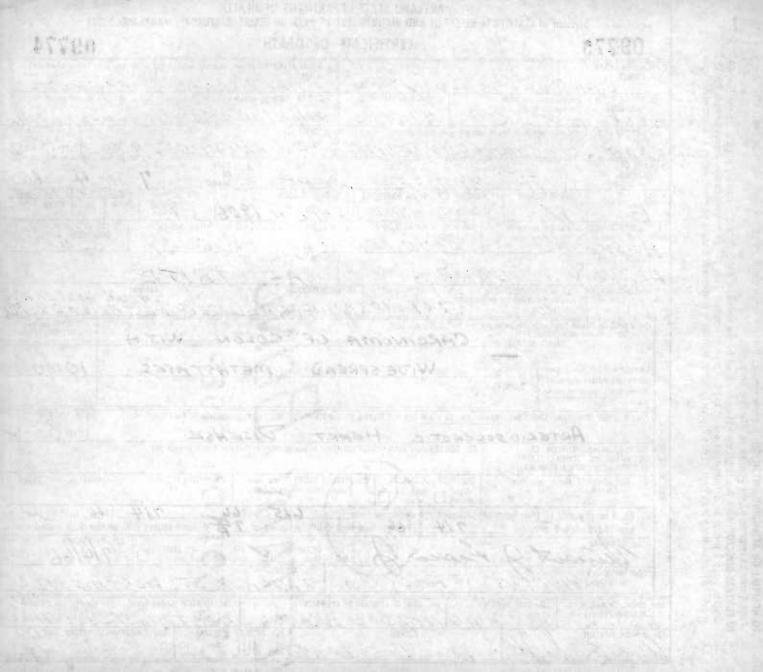
MARYLAND STATE DEPARTMENT OF HEALTH

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MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND FOR STATE MEDICAL EXAMINER'S CERTIFICATE OF DEATH HEALTH DEPT. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. COUNTY Maryland Carroll Carroll MARYLAND funeral may be CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) C. LENGTH OF STAY IN 1b Rural - Millers Westminster
d. NAME OF HOSPITAL OR INSTITUTION (if not In hospital, give street address) 5 d. STREET ADDRESS e. IS RESIDENCE ON A FARM? ay 13 to Page State YES X NO Carroll County General Hospital and 3. 3. NAME OF First Middle Last DATE Month Day DECEASED the YELTON 19 66 REBECCA 14 DEATH (Type or print) with 6. COLOR OR RACE | 7. MARRIED | NEVER MARRIED DATE OF BIRTH AGE (In years | IF UNDER 1 YEAR | IF UNDER 24 HRS. | Hours | Min. after death. If a Give Pages 1, ong with form 5. SEX Female 11/27/90 White WIDOWED . DIVORCED 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT COUNTRY? USA North Carolina Hwf. along pages in any 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME 24 hou. ... Item 18 Amanda Jane Street Charles R. Yelton in pencil in Item Examiner's Office File 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 17. INFORMANT 16. SOCIAL SECURITY NO. Address (Yes, no, or unkown) (If yes give war or dates of service) Millers, Md. 213-16-1037 Mr. Henry Yelton EXAMINER: This certificate should be executed within certificate, writing the word "pending" in pencil is nould be forwarded to the Chief Medical Examiner's no INTERVAL BETWEEN 18. CAUSE OF DEATH [Enter only one cause, per line for (a), (b), and (c).] ONSET AND DEATH PART I. DEATH WAS CAUSED BY: burial-transit cremation, or IMMEDIATE CAUSE (e) cremation, DUE TO Conditions, If any, which geve rise to immediate DUE TO cause (e), steting the the word " a underlying cause last. used as to burial, WAS AUTOPSY CERTIFICATION PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(e) 19. PERFORMEQ? NO 20a. EXTERNAL CAUSE WAS PRIMARY OF CONTRIBUTING CAUSE OF DEATH. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part) or Part) of Item 48.) Frustured We chen should ent, pri 3 shou MEDICAL 20c. TIME OF INJURY, Month, Dey, Year 20d, INJURY OCCURRED | 20e. PLACE OF INJURY (Home, farm, 20f. (City or town) (County) (State) factory, street, office bldg., etc.) While Not While CTOR: Page designated at work at work 21. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry and In my opinion X. files. FUNERAL DIRECTOR: Natural causes 13 Undetermined manner death resulted from: Accident \ Suicide Homlcide CHIEF MEDICAL EXAMINER Your 22. OATE SIGNED ASSISTANT MEDICAL EXAMINER SIGNATURE for 10 DEPUTY MEDICAL EXAMINER X Health **EXAMINER'S** director. retained Address (Street City town Isloculity Mileres NAME (Type) BURIAL, CREMATION, REMOVAL_(Specify) 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) (State 0 Kirkridge Cemetery Md. 17/66 Burial REC'D BY REGISTRAR REGISTRAR'S SIGNATURE 24. FUNERAL DIRECTOR VR ALSME (5)Q Tipton-Eline Hamstead. Md. 1/65

Indicase Large of White Directed STATE OF THE STREET The result of the second of the second secon The ica-silace . More based, id.

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH 09775 be executed within 24 hours after death. 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission) and completely filled in by the funera remove carbon papers. Pages trand o. COUNTY b. COUNTY b. CITY OR TOWN (If outside corporate limits, c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) write RURAL and give nearest tawn) ESTMINSTE d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS IS RESIDENCE ON A FARM? within 72 MANCHIEST YES NO A 3. NAME OF Lost 4. DATE Month Year Doy DECEASED 1966 (Type or print) DEATH 9. AGE (In years lost birthdoy) S. SEX IF UNDER 1 YEAR IF UNDER 24 HRS. 6. COLOR OR RACE 7. MARRIED NEVER MARRIED DATE OF BIRTH Months Doys Hours WIDOWED DIVORCED 10o. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT during most of working life, even if retired) INDUSTRY COUNTRY? requires that the death certificate 1005EW11=6 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME Address 24 MANCHESTERAVE WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO 17. INFORMANT (Yes, no, or unknown) (If yes give wor or dotes of service) 217-09-0703 MR. HERSCH WESTMINSTER 1B. CAUSE OF DEATH (Enter only one cause per line for (o), (b), and (c).) INTERVAL BETWEEN buriol-tronsit ONSET AND DEATH PART I. DEATH WAS CAUSED BY: CARCINOMA COLON WITH IMMEDIATE CAUSE (o) DUE TO WIDE SPREAD 10mo. Conditions, if ony, which gove METHSTHSES rise to immediate couse (a), DUE TO stoting the underlying couse as the this certificate has been lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) 19. WAS AUTOPSY PERFORMED? NO L YES HRTERIO SCLEROTIC by the hospitol or for 20o. ACCIDENT WAS UNDERLYING [20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.) OR CONTRIBUTING CAUSE OF DEATH 90 detached (IF EITHER, NOTIFY MEDICAL EXAMINER 20c. TIME OF INJURY Month, Doy, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, 20f. (City or town) (County) (Stote) Hour o.m. foctory, street, office bldg., etc.) O FUNERAL DIRECTOR: After ot work 1966 to 1966, that (1) (we) last 21. I certify that (1) (this haspital) attended the deceased fram 1966, and that death accurred at 7 & M, fram causes and an the date stated above saw the deceased alive an 220. SIGNATURE 22b. DATE SIGNED **ATTENDING** MED. DIRECTOR STAFF PHYS. M.D. 22d. ADDRESS 224. PHYSICIAN'S NAME (Type) 10000 ANCHOR director, p 23c. NAME OF CEMETERY OR CREMATORY 23o. BURIAL, CREMATION. 23b. DATE THEREOF 23d. LOCATION (City or Town) (County) REMOVAL (Specify) FUNERAL DIRECTOR 2So. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE VR A15 (40 20 M 1/66 DATE JU 1956 mes 6



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 09776 CERTIFICATE OF DEATH by the funeral Bages 1 and 2 haurs after death death. 2. USUAL RESIDENCE (Where deceosed lived, if institution; Residence before odmission) PLACE OF DEATH o. COUNTY o. STATE b. COUNTY Maryland Carroll Frederick ician and completely filled in by the fur lease remove carbon popers. Pages 1 and in any event, within 72 haurs after MARYLAND 24 haurs after c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) b. CITY OR TOWN (If outside corporate limits, CLENGTH OF STAY IN 16 rural) Sykesville 20d Frederick e. IS RESIDENCE ON A FARM? d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS Springfield State Hospital 207 W. 7th. Street YES NO TO The low requires that the deoth certificate be executed within Middle 3. NAME OF First DATE Lost Doy Year DECEASED OF 19 66 Grafton Zimmerman Bernard (Type or print) DEATH IF UNDER 24 HRS. B. DATE OF BIRTH IF UNDER 1 YEAR S. SEX 6. COLOR OR RACE AGE (In years 7. MARRIED NEVER MARRIED birthdoy) Months lost Hours Dovs 1-1-65-1895 WIDOWED DIVORCED white male 12. CITIZEN OF WHAT COUNTRY? 10o. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & Stote, or foreign country) during most of working life, even if retired)
Truck driver **INDUSTRY** ottending physician permit. Then please Maryland 14. MOTHER'S MAIDEN NAME 13. EATHER'S NAME J cremotion, or removol, Edward J. George Zimmerman Amanda Stalev 17. INFORMANT IS. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. Address (Yes, no, or unknown) (If yes give wor or dotes of service) permit. NAKK KAND Hospital Records INTERVAL BETWEEN 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), ond (c).)
PART I. DEATH WAS CAUSED BY: signed by the burial-transit p burial, cremotic ONSET AND DEATH Acute pulmonary embolism IMMEDIATE CAUSE (o) Page 4 may be retained by the hospital or attending physician. **O FUNERAL DIRECTOR:** After this certificate has been signed by director, page 3 should be detached for use as the burial-transhould be filed with the State Dept. of Health prior to burial, crei DUF TO Weeks Months Infected gangrenous decubitus ulcers Conditions, if ony, which gove (b) rise to immediate couse (a). DUE TO stoting the underlying couse Days Bronchopneumonia PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0)

Chronic brain syndrome associated with diseases of unknown or WAS AUTOPSY PERFORMED? YES X NO uncertain cause. Huntington's Chorea, with psychotic reaction

20o. ACCIDENT WAS UNDERLYING

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 1B.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20e. PLACE OF INJURY (Home, form, (City or town) (County) (Stote) 20c. TIME OF INJURY Month, Doy, Year 20d. INJURY OCCURRED Not While foctory, street, office bldg., etc.) Hour o.m. of work L 19 65 that (M (we) last 19 60 21. I certify that (1) (this haspital) attended the deceased fram. クーエン odt. saw the deceased plive an 7-5-19 66, and that death accurred at 4:30M, fram causes and an the date stated above. 22b. DATE SIGNED 220 SIGNATURE 7-6-66 DIRECTOR PHYS. M.D. PHYS. 22d. ADDRESS PHYSICIAN'S A. Arengo, M.D. Springfield State Hospital NAME (Type) 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (Stote) 23b. DATE THEREOF (County) 23o. BURIAL, CREMATION, REMOVAL (Specify) Frederick, Md. 21701 Mt. Olivet Cemetery July 9-1966 0 2So. REC'D BY REGISTRAR 2Sb. REGISTRAR'S SIGNATURE 24. FUNERAL DIRECTOR Markey VR A15 (4) 20 M 1/66 Frederick, Md.21701 1966 M.R. Etchison & Son DATE

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